2023 Summary Plan Description

Baker Hughes™

This document describes the Baker Hughes Health programs effective January 1, 2023.

Please note that the information presented is only a summary. It replaces all previously published Health Summary Plan Descriptions. The actual eligibility requirements, benefits, terms, conditions, limitations, and provisions that govern these plans are contained in the plan documents or group insurance contracts. If, in our efforts to make the plans easy to understand, any of the plan provisions have been omitted or misstated, the official plan documents or insurance contracts must remain the final authority. The legal documents also govern the administration of the plans and payment of benefits. In the case of any dispute, the information in the plan documents or contracts will prevail. To request a copy of the plan documents, write to:

Baker Hughes Company
Attn: Employee Benefits Department
575 N. Dairy Ashford, Energy Center II
Houston, TX 77079-1117

The information contained in this document is intended to meet the federal disclosure requirements for Summary Plan Descriptions of employee benefit plans. Baker Hughes intends to continue the plans indefinitely. However, Baker Hughes reserves the right to amend, cancel, change the carrier, or discontinue all or any part of the plans at any time.

This Summary Plan Description does not guarantee employment for any specified term and is not to be construed as a contract limiting Baker Hughes right to terminate the employment relationship at any time.

This document contains a summary in English of your **Baker Hughes** Health programs. If you have difficulty understanding any part of this document, contact the **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** between 7 a.m. and 7 p.m. Central Time, Monday through Friday.

Este documento contiene un resumen en inglés de los programas de beneficios de salud y bienestar de **Baker Hughes**. Si tuviera alguna dificultad para entender alguna parte de este documento, por favor comuníquese con el **Baker Hughes Benefits Center** al **1-847-883-0945** (resto del mundo) o **1-866-244-3539** en los Estados Unidos entre 7 a.m. y 7 p.m., tiempo central, de lunes a viernes.

About Your Baker Hughes Summary Plan Description

This Health Program document, called a Summary Plan Description (SPD), gives you information about benefits offered at Baker Hughes effective January 1, 2023. It describes important features of each benefit plan, services that are covered, and how your benefits are paid.

To help you find information quickly, this SPD is divided into four main sections:

- General Information — details about eligibility, enrollment procedures, and when coverage starts and ends for all the plans;
- Health and Protection — information about your Medical, Prescription Drug, Dental, Vision, Salary Continuation, and Long-Term Disability programs;
- Benefits Rights — information about your rights under the law and continuation of coverage if you leave Baker Hughes, and;
- Important Plan Information — reference details, such as plan number, sponsor, and the administrator.

It's important for you to understand your benefit choices and how these benefits can work for you. Within this document we have included definitions, reminders, tips, and tools to highlight key information. Please keep this SPD for future reference.

This guide provides information for the following benefits:

- Medical program (includes vision benefit)
- Telemedicine
- Prescription Drug coverage
- Dental program
- Vision program
- Salary continuation
- Long-Term Disability coverage

Who to Call If You Have Questions

If you don't have Internet access, the *Contacts* table on the next page provides you with telephone contact information. Before you pick up the telephone, reference the table below to ensure you call the right resource.

Contact the Baker Hughes Benefits Center Regarding:	Contact Your Human Resources Department Regarding:	Contact the Administrator or Insurance Company Regarding:
• Eligibility for coverage • The cost of your Health benefits • Changes in status that may affect your benefits (such as enrolling a new dependent due to birth, marriage, or adoption) • Updating beneficiary information • Changes in work status (such as from full-time to part-time) that may affect your benefits • Your benefit options • The Annual Enrollment process • Your confirmation statements • Obtaining help with a health care issue or claim	• Taking a leave of absence • Filing a Workers' Compensation claim • Transferring within Baker Hughes • Leaving Baker Hughes • Changing your address or phone numbers via Employee Self Service (ESS)	• ID cards • Network providers, facilities, hospitals, and pharmacies • Questions or disputes about your Explanation of Benefits (EOB) or Health Statement • The status of a claim or an appeal • Your covered benefits • How to file a claim

Baker Hughes Benefits

Go to **BakerHughesBenefits. com/Assignee/US** and click *Enroll, Review, or Change Benefits*. Then select *Health & Protection Benefits*. If you are accessing the site from inside the Baker Hughes firewall, select *Single sign-on from Baker Hughes intranet*. If you are accessing the site outside the firewall, select *Access with login and password*. The first time you access the site, you'll have to register and authenticate that it's you. For your added security, the enrollment tool requires multi-factor authentication.

- You will need your work email and employee ID or Social Security Number to start the process. An email with an authentication code will be sent to your email address on file. Type that code into the box on the screen.
- Then the site will ask you to type in a mobile phone number where you can receive a text. This is called multi-factor authentication.
- Check your text messages for a code to type into the box on the screen.
- Create a password at least eight characters long. The site will require you to include a combination of capital and lowercase letters, numbers, and symbols.
- Each time you log in, you will be required to use multi-factor authentication (sending your mobile phone a text with a code). Access is available 24 hours a day, seven days a week.

Baker Hughes Benefits Center

1-847-883-0945 (worldwide)

1-866-244-3539 (within the U.S.)

With your user ID and password, you can access your personal account information. Please say "representative" at any time to speak with a **Baker Hughes Benefits Center** representative. Representatives are available Monday through Friday from 7 a.m. to 7 p.m. Central Time.

Contacts

Below you'll find the customer/member services telephone numbers and websites for the administrators and insurance companies that administer the Baker Hughes health program benefits.

Benefit Program	Provider	Phone Number	Website
Enrollment, Eligibility, Summary Plan Descriptions, and Advocacy	Baker Hughes Benefits Center	**1-847-883-0945** (worldwide) **1-866-244-3539**	**BakerHughesBenefits. com/Assignee/US**
Medical (includes Prescription Drug, Dental, and Vision)	Cigna International	**1-800-441-2668** (worldwide) **302-797-3100** (collect) **302-797-3150** (fax)	**www.cignaenvoy.com**
Telemedicine	Cigna International	**1-800-441-2668** (worldwide) **302-797-3100** (collect) **302-797-3150** (fax)	**www.cignaenvoy.com**
Dental	Cigna International	**1-800-441-2668** (worldwide) **302-797-3100** (collect) **302-797-3150** (fax)	**www.cignaenvoy.com**
Long-Term Disability (LTD)	Baker Hughes Benefits Center	**1-847-883-0945** (worldwide) **1-866-244-3539**	**BakerHughesBenefits. com/Assignee/US**
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	Baker Hughes Benefits Center	**1-847-883-0945** (worldwide) **1-866-244-3539**	**BakerHughesBenefits. com/Assignee/US**

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Baker Hughes

General Information

The following section describes general information about coverage including:

- Eligibility
- How to Enroll
- Default Coverage
- Identification Cards
- Making Changes After Enrollment

Eligibility

Employee Eligibility

If you are an active U.S. Assignee/Rotator working a minimum of 20 hours per week, you're eligible for coverage under the benefit programs described in this SPD. Members are allowed to appeal a determination of an individual's eligibility for coverage (see next page).

Note: You'll be notified by Baker Hughes if you're benefits-eligible when you're hired or transferred to a new assignment within the company.

Excluded Eligible Employees

- Temporary, contract, or seasonal employees;
- Persons for whom coverage is prohibited under applicable law will not be considered eligible under this plan; and
- Employees who are members of a bargaining unit whose agreement does not provide for these benefits.

Remember...

Call the Baker Hughes Benefits Center at 1-847-883-0945 (worldwide) or 1-866-244-3539 (toll-free in the U.S.) with questions about eligibility for coverage.

Eligible Dependents

If you're an eligible employee as defined above, you may cover your eligible dependents under your Baker Hughes Health programs. Eligible dependents include:

Family Member	Eligibility Requirements
Your Spouse	• Your legal spouse of opposite or same gender, including common-law in states recognizing common-law marriage, or a legally separated spouse in states recognizing legal separation.
Your Children	• Your dependent children up to age 26 regardless of whether they are married, full-time students, or eligible for other group health plan coverage, or • Your unmarried dependent children up to any age who are supported by you because of mental or physical disability; the disability must have occurred during the period in which they were an eligible dependent under the Health programs (up to age 26).

Eligible Children

- Your biological children
- Your adopted children and children placed for adoption
- Your stepchildren
- Foster children in your care
- Any children for whom you have legal custody
- Any children for whom there is a Qualified Medical Child Support Order (QMCSO)

Excluded Eligible Dependents

- A spouse who is in full-time military service
- Parents, siblings, grandparents, nieces, nephews, etc., under the Medical, Dental, or Vision programs
- Domestic partners

Special Note on Dependent Children

Please contact the **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.) if there are any changes to your dependents' status. Your dependent will lose eligibility on his or her 26th birthday, and coverage will be terminated on the last day of the month in which he or she turns 26.

Please note that you have 60 days after the birth of a newborn to enroll him or her in the Medical program. Any dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 60 days after his or her birth. If you do not elect to insure your newborn child within such 60 days, coverage for that child will end on the 60th day. No benefits for expenses incurred beyond the 60th day will be payable.

Contact the **Baker Hughes Benefits Center** at **1-866-244-3539** to enroll your newborn.

Note: Upon request, you may be required to comply with the Baker Hughes Dependent Eligibility Verification process. As a result, you may be required to provide proof of dependent eligibility for any dependents covered under a Baker Hughes-provided benefit program. Intentionally covering ineligible persons under the Baker Hughes Health programs may be subject to discipline, up to and including termination. You must immediately notify the Benefits Center if your dependent becomes ineligible.

If Eligibility for Benefits Coverage is Denied — How to Appeal

If eligibility for benefits coverage has been denied, you have the right to file an appeal under Section 503 of the Employee Retirement Income Security Act (ERISA), as described below:

- Request a Claim Initiation Form from the Baker Hughes Benefits Center within 60 days after receipt of eligibility denial. You may contact the Baker Hughes Benefits Center at 1-847-883-0945 (worldwide) or 1-866-244-3539 (toll-free in the U.S.);
- Complete the Claim Initiation Form, provide a description of the nature of the claim (e.g., calculation of service, eligibility for coverage) and a statement of the reason why you think you are entitled to such coverage or benefit;
- Return all pages of the form, including any documentation you feel supports your claim. Please do not submit any original documentation. Documents submitted for claim processing cannot be returned to you. Keep a copy of this form for your records; and
- Mail all pages of the original form along with any documentation to:

  Baker Hughes
  Attn: Total Rewards H&W Department Appeals
  575 N. Dairy Ashford, Energy Center II
  Houston, TX 77079-1117

A decision on the review will be made by Baker Hughes under Section 503 of the Employee Retirement Income Security Act (ERISA), as described below.

- Baker Hughes will process your claim within 60 days after receiving the Claim Initiation Form, unless special circumstances require an extension of time;
- If Baker Hughes needs additional time to process your claim, you will receive a written notice of the need for a longer processing period, the reasons for the longer period, and a date on which you can expect your claim to be processed; and
- The decision on the review will be made in writing, include specific reasons for the decision and will reference the plan provision on which the decision is based.

How to Enroll

There are two ways to enroll in the health programs.

Online	Phone
From **BakerHughesBenefits.com/Assignee/US**, click on *Enroll, Change, or Review Benefits*. And then select *Health & Protection Benefits*. If you are accessing the site from inside the Baker Hughes firewall, select *Single sign-on from Baker Hughes intranet*. If you are accessing the site outside the firewall, select *Access with login and password*. The first time you access the site, you'll have to register and authenticate that it's you. For your added security, the enrollment tool requires multi-factor authentication. • You will need your work email and employee ID or Social Security Number to start the process. An email with an authentication code will be sent to your email address on file. Type that code into the box on the screen. • Then the site will ask you to type in a mobile phone number where you can receive a text. This is called multi-factor authentication. • Check your text messages for a code to type into the box on the screen. • Create a password at least eight characters long. The site will require you to include a combination of capital and lowercase letters, numbers, and symbols. • Each time you log in, you will be required to use multi-factor authentication (sending your mobile phone a text with a code). Access is available 24 hours a day, seven days a week.	Call the **Baker Hughes Benefits Center** **1-847-883-0945** (worldwide) **1-866-244-3539** (within the U.S.) Health & Protection representatives are available Monday - Friday, 7:00 a.m. to 7:00 p.m. CST. If you're a new hire or an existing employee transferring to a position with U.S. Assignee/Rotator benefits, you can enroll via the telephone after you receive your first paycheck.

Tip!

Baker Hughes automatically provides Benefits Connect with your Baker Hughes email address. If you forget your password, a password reset can be sent to your Baker Hughes email address within 15 minutes of your request unless you prefer to set up a personal email address as your preferred email.

When to Enroll

Annual Enrollment

Annual Enrollment occurs each year, typically during October or November. This is the time when you may review your current coverage and think about what you'll need in the coming year.

If You Do Not Enroll

If you do not enroll during Annual Enrollment and you remain eligible to participate in the programs, you will receive the benefit options and coverage levels you had the previous year.

New Hires

If you're a new hire or an existing employee transferring to a position with U.S. Assignee/Rotator benefits, you will automatically be enrolled with *Employee Only* medical coverage after 60 days of your date of hire or date of transfer. You may choose to enroll in dental coverage for you and your eligible dependents within 60 days of date of hire or date of transfer. You can enroll online via **BakerHughesBenefits.com** or via phone through the Baker Hughes Benefits Center by calling **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.) after you have received your first paycheck.

If you do not enroll within 60 days, you'll be provided the default coverage shown below. (Default coverage may be different for employees transferring to U.S. Assignee/Rotator benefits.) If you do not want default coverage, you must enroll and choose the coverage you do want or select the "No Coverage" option. You will only be able to change these elections during the Annual Enrollment period typically held in October or November of each year, or if you have a change in status such as the birth or adoption of a child. If you have a change in status, you will need to make your election within 60 days of the date the change occurred. Please see the *Making Changes After You Enroll* information located in this section for more details.

Your Default Coverage

	Benefit Program	Default Coverage Level
Health	**Medical and Prescription Drug***	You Only coverage under the Cigna International plan and Prescription Drug coverage through Cigna
	Telemedicine	Included in Medical program
	Dental	No coverage
	Vision	Included in Medical program
Protection	**Salary Continuation**	Continuation of your base pay
	Long-Term Disability (LTD)	60% of benefits base pay, up to $15,000 per month

*You will be required to pay for the default Medical (including Vision and Prescription Drug) coverage.

Tip!

If you are planning to retire and you meet the eligibility requirements for age and years of service, you must also be enrolled in a Baker Hughes Medical program at the time of your retirement to be offered retiree medical benefits.

Identification Cards

Your ID card shows the type of plan, your coverage, and other information to help your physician, pharmacist, or health care provider verify your eligibility or submit your claim.

After you enroll, your Medical and Prescription Drug, and/or Dental Plan Administrator will send identification cards to your address on file at Baker Hughes. You can also go to **www.cignaenvoy.com** to print an ID card for your medical, dental, vision, and prescription drug benefits through Cigna International.

If you don't receive a card or you would like additional cards, contact Cigna International at the contact information listed below.

Remember...

Under the Cigna International plan, you automatically receive Prescription Drug coverage through Cigna, both within and outside the U.S.

CignaLinks ID cards

For employees in Australia, the Middle East, Spain, Brazil, Canada, or Africa (South Africa, Tanzania, Kenya, Morocco, Egypt, and Nigeria) you will receive two cards — your Cigna International Medical ID card and a separate card for the local insurance carrier. Make sure you use your local ID card when making claims in those countries. You will receive a dual-branded ID card for Greater China, Southeast Asia, and the United Kingdom.

Program	Administrator	Website	Telephone
Medical (includes Prescription Drug and Vision)	Cigna International	**www.cignaenvoy.com**	**1-800-441-2668** (worldwide) **302-797-3100** (collect) **302-797-3150** (fax)
Dental	Cigna International	**www.cignaenvoy.com**	**1-800-441-2668** (worldwide) **302-797-3100** (collect) **302-797-3150** (fax)

Note: You have one card for medical, dental, vision, and prescription drug benefits through Cigna International. Print your ID card from **www.cignaenvoy.com**.

Making Changes After You Enroll

The elections you make during the Annual Enrollment period stay in effect for the entire plan year (January 1 through December 31). However, during the year you may change certain elections if you have a change in family or employment status (qualified status change). These are defined by the Internal Revenue Service (IRS) and include changes such as marriage, the birth or adoption of a child, or career-related changes such as moving from a part-time status that is not benefits-eligible to full-time status.

The benefit changes that are permitted must generally be made within **31 days** of the change in status or the coverage you had before the change will remain in effect for the full plan year (certain exceptions apply).

Approved IRS Qualified Status Change

- If you marry;
- If you return from an unpaid leave of absence;
- If you divorce, your marriage is annulled, or you become legally separated (in states that recognize legal separation);
- If you gain or lose benefits eligibility due to a work situation change;
- If you have a birth, adoption, placement for adoption, or court-ordered guardianship;
- If COBRA coverage from another employer expires;
- If you die;
- If the employee or dependent gains or loses Medicare coverage;
- If your spouse or child dies;
- If a family member gains or loses benefits eligibility due to a work situation change;
- If the employee or dependent loses eligibility for, or becomes eligible for, assistance under Medicaid or a state child health plan*;
- If you take an unpaid leave of absence;
- If a child loses or gains eligibility under the Health program; or
- If there is a qualifying change in coverage or cost of coverage.

*The approved changes must be made within 31 days of the date eligibility is lost, or within 31 days from the date the employee or dependent is determined to be eligible for assistance under Medicaid or a state child health plan.

How to Make an Approved Change After You Enroll

The approved changes must be made within the time frame specified above. To make the approved changes, access benefits or contact the **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.), Monday through Friday, 7 a.m. to 7 p.m. Central Time.

Tip!

In most cases, changes to your benefits must be consistent with the qualified status change. For example, if you get married, you may add your spouse. Go to **BakerHughesBenefits.com** and click *Enroll, Review, or Change Benefits*. Then select *Health & Protection Benefits*. If you are accessing the site from inside the Baker Hughes firewall, select *Single sign-on from Baker Hughes intranet*. If you are accessing the site outside the firewall, select *Access with login and password*. You can also call the **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.).

When Coverage Begins

Newly Hired or Transferred Employee

If you're a newly hired or an existing employee transferring to an assignment, you are eligible for benefits on your date of hire or date of transfer and you may enroll after you receive your first paycheck from Baker Hughes after your transfer. You must complete the benefits enrollment process within 60 days from your date of hire or date of transfer (see the *How to Enroll* section). Any dependents that you enroll during that time are also covered immediately. If you do not actively enroll or actively decline coverage within 60 days of becoming eligible, you'll automatically be enrolled in the default benefits listed in the *Your Default Coverage* section.

Remember...

If you elect new coverage during Annual Enrollment, your new coverage will take effect the following January 1.

Current Employee

If you're an existing employee, any new coverage you elect during Annual Enrollment will generally take effect the following January 1. If you have a qualified status change, and make a timely benefit coverage change, your new coverage will take effect on the date of your status change. In other words, if the change is due to birth, adoption, placement for adoption, or marriage, etc., the change will generally take effect retroactively to the date of the birth, adoption, placement, or marriage etc., as long as the change is made within 31 days of the event.

If you enroll eligible dependents in the plan, their coverage will start on the later of the following dates:

- Date your coverage becomes effective; or
- Date you enroll your dependents for coverage; if enrollment is due to a status change, coverage will start as of the effective date of the status change (e.g., the date of birth).

When Coverage Ends

Coverage for you and/or your eligible dependents will end on the day:

- You stop working for Baker Hughes
- You're no longer eligible
- You stop making contributions to the plan
- Your dependent is no longer eligible

Benefit coverage for your eligible dependents ends either on the day that they no longer qualify as dependents, or on the day that your coverage ends for one of the reasons above, whichever comes first. (Please note that a dependent child loses coverage on the last day of the month in which he or she turns 26.)

Note: If your group health plan coverage terminates, you may be eligible to continue your health coverage by electing coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA coverage continues the same health coverage you have as an employee, but you pay the full premiums plus a 2% administration fee. Refer to the *COBRA* section for more information on COBRA coverage.

Your coverage may not be rescinded (retroactively terminated) by Cigna or the program sponsor unless the program sponsor or an individual (or a person seeking coverage on behalf of the individual) either:

- As a result of an act, practice, or omission by the individual that constitutes fraud or another person, such as the employee or employee's spouse, seeking coverage on behalf of the individual under the Medical program that constitutes fraud, or
- As a result of an intentional misrepresentation of a material fact made by such individual.

If any of the above circumstances occurs, then both the eligible employee and any affected eligible dependents will be given at least 30 days advance written notice of the rescission.

If You Retire

Baker Hughes offers Medical benefits to our retired employees. To be eligible, you must be considered a retiree of Baker Hughes on your date of retirement. You will need to be at least age 60, with at least 10 years of service, and enrolled in an eligible Baker Hughes Medical program on the date of retirement. If you're an eligible retiree and would like more information, contact the **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.).

While Baker Hughes intends to provide medical coverage for retirees now and in the future, Baker Hughes reserves the right to amend, cancel, change the carrier for, or discontinue all or any part of the medical coverage provided to retirees at any time.

If You Become Disabled

If you become disabled, you and your dependents may continue to receive Baker Hughes Health benefits as follows:

Benefits	Coverage Under Salary Continuation, When Eligible	Coverage Under Long-Term Disability, When Eligible
"Health" benefits, including Medical, Prescription Drug, Dental, and Vision	All benefits are continued during the Salary Continuation period.	You may elect to continue Medical, Dental, and Vision. For information on *COBRA* coverage, refer to the *COBRA* section of this Summary Plan Description.

If You Die

If you die while you're an active employee of Baker Hughes, your eligible dependents may elect to continue to be covered under a group health plan through COBRA and pay the applicable COBRA premiums. The first three months of COBRA coverage will be at the active employee rate. Refer to the *COBRA* section for more information.

COBRA coverage will end if your eligible dependents:

- Notify the Baker Hughes Benefits Center they have become covered under another group health plan or Medicare;
- Is/(are) no longer eligible;
- No longer makes the required contributions; or
- COBRA coverage expires.

When Coverage Ends for Any Other Reason

If coverage ends for any reason other than retirement, disability, or death (such as you leave Baker Hughes), coverage for you and your dependents will end on the earliest of the following dates:

- You stop working for Baker Hughes;
- You're no longer benefits-eligible;
- You or your dependents are no longer eligible as described in the *Eligibility* section; or
- The plan ends.

If your employment ends, you may be eligible to continue your health coverage by electing COBRA (see the *COBRA* section for more information).

Termination of Coverage

Employees

Your coverage under the plan will cease on the earliest date below:

- The date you cease to be in a class of eligible employees or cease to qualify for the coverage;
- The last day for which you have made any required contribution to the plan;
- The date the plan is terminated; or
- The date your active service ends except as described below.

Any continuation of coverage must be based on a plan that precludes individual selection.

Dependents

Your coverage for all of your dependents will cease on the earliest date below:

- The date your coverage ceases;
- The date you cease to be eligible for dependent coverage;
- The last day for which you have made any required contribution for the coverage; or
- The date dependent coverage is canceled.

The coverage for any one of your dependents will cease on the date that dependent no longer qualifies as a dependent.

Baker Hughes

Health

The following section Benefits described under Health are designed to help create a healthier life for you and your family. These benefits include:

- Medical plan
- Telemedicine
- Prescription Drug
- Dental
- Vision

Medical Program

Medical Benefits At-a-Glance

Type of Plan	Voluntary medical coverage
Who Pays the Cost	You share the cost of medical coverage with Baker Hughes.
Employee Eligibility	U.S. Assignees/Rotators who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Coverage begins on your date of hire or date of transfer.
Enrollment Period	• New hires and employees transferring to a position with U.S. Assignee/Rotator benefits, within 60 days of becoming eligible for coverage. If you do not enroll, you'll be given default coverage. • Employees can change their Medical program election during Annual Enrollment or during the year if they have a qualified status change (see the *Making Changes After You Enroll* information located in the *General Information* section). If you do not enroll during the Annual Enrollment period, you'll receive the same coverage you had the previous year as long as you remain eligible.
Medical Program	Cigna International plan
Coverage Level	• You Only* • You + Children • You + Spouse • You + Family
Contact	• Cigna: **www.cignaenvoy.com** | **1-866-441-2668** (worldwide) or **302-797-3100** (collect outside the U.S.) • **BakerHughesBenefits.com/Assignee/US** • The **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.)

*You Only coverage is required for U.S. Assignees/Rotators

Medical

Our Medical program helps you manage your health, whether that means treating a specific problem or just using free preventive care to make sure everything's in working order. Please note that you'll always save with network providers. Our Medical program allows you to receive medical care through the Cigna network of physicians, specialists, hospitals, and clinics at pre-negotiated fees, which are usually lower than what you pay outside the network.

This chart details some highlights of your medical coverage.

Benefit Details	International	U.S. In-Network	U.S. Out-of-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Deductible	No deductible	No deductible	$1,000 Individual/$2,000 Family
Coinsurance	100% of covered expenses	80% of covered expenses	60% of covered expenses
Preventive Care	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Physician Office Visit	100% not subject to deductible	80% not subject to deductible	60% after deductible
Emergency Room	100% not subject to deductible	80% not subject to deductible	80% not subject to deductible
Outpatient Surgery	100% not subject to deductible	80% not subject to deductible	60% after deductible
Inpatient Hospital	100% not subject to deductible	80% not subject to deductible	60% after deductible
Out-of-Pocket Maximum	In the U.S.: $2,000 individual/$4,000 family Outside the U.S.: $4,000 individual/$8,000 family		
Prescription Drug Coverage	When you enroll in Medical, you automatically receive Prescription Drug coverage. Refer to the *Prescription Drug* section for details.		

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

To ensure that your coverage fits your needs, you can choose from four different levels of coverage:

- You Only*
- You + Spouse
- You + Children
- You + Family

As a newly hired employee or a transfer to a benefits-eligible position, you must enroll within the first 60 days of your date of hire or transfer. If you do not make an enrollment election, you'll be covered by the Cigna International Plan with You Only coverage. Default coverage may be different for employees transferring to U.S. Assignees/Rotators benefits (contact the **Baker Hughes Benefits Center** for assistance).

**You Only coverage is required for U.S. Assignees/Rotators*

Medical Program

Remember...

In a true medical emergency, call 911 if you are in the United States, or seek immediate treatment from the nearest emergency medical facility.

The program's key features are outlined below.

- Worldwide coverage;
- Nationwide network of providers in the U.S.;
- In-network and out-of-network coverage;
- No designation of primary care physician or referral required for specialist visit;
- You are required to meet the deductible before the program will begin to share in the cost of covered services with you;
- Services received outside the U.S. are not subject to a deductible;
- Preventive care is covered at 100% in-network (no deductible applies); and
- Most international services are covered at 100%, and most U.S. services are covered at 80% in-network not subject to the deductible or 60% out-of-network after the deductible is met. U.S. out-of-network services are subject to Covered Expense cost limits and you are required to submit a claim form for reimbursement.

Tip!

You will always save with network providers. Our Medical program allows you to receive medical care through the Cigna network of physicians, specialists, hospitals, and clinics at pre-negotiated fees, which are usually lower than you'd pay outside the network.

Preferred Provider Medical Benefits

Notice Regarding Provider Directory Networks

When you select a participating provider, the cost for medical services provided will be less than when you select a non-participating provider. Participating providers include physicians, hospitals, and other health care professionals and other health care facilities. You can access a list of participating providers in your area at **www.cignaenvoy.com**. Participating providers are committed to providing you and your dependents appropriate care while lowering medical costs.

Certification Requirements – U.S. Out-of-Network

For You and Your Dependents
Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of a hospital confinement when you or your dependent require treatment in a hospital:

- As a registered bed patient, except for 48/96 hour maternity stays; and
- For Mental Health or Substance Abuse Residential Treatment Services.

You or your dependent should request PAC prior to any non-emergency treatment in a hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued hospital confinement.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include any hospital charges for treatment listed above for which PAC was requested, but that was not certified as medically necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted. In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the *Coordination of Benefits* section.

Outpatient Certification Requirements – U.S. Out-of-Network

Outpatient Certification refers to the process used to certify the medical necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a free-standing surgical facility, other health care facility, or a physician's office. You or your dependent should call the toll-free number on the back of your ID card to determine if outpatient certification is required prior to any outpatient diagnostic testing or procedures. Outpatient certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient certification should only be requested for non-emergency procedures or services, and should be requested by you or your dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which outpatient certification was performed, but that was not certified as medically necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the *Coordination of Benefits* section.

Outpatient Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA, or PET scans
- Home health care services
- Medical pharmaceuticals
- Radiation therapy

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a participating provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- Inpatient hospital services, except for 48/96 hour maternity stays
- Inpatient services at any participating other health care facility
- Residential treatment
- Outpatient facility services
- Partial hospitalization
- Advanced radiological imaging
- Non-emergency ambulance
- Certain medical pharmaceuticals
- Home health care services
- Radiation therapy
- Transplant services

Coverage includes immediate access, without prior authorization, to a 5-day emergency supply of covered, prescribed medications for the medically necessary treatment of Mental Health and Substance Use Disorder, where an emergency medical condition exists. The emergency supply **www.cignaenvoy.com** requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

You and CignaLinks

CignaLinks, part of the Cigna International Medical plan, is a collaboration between Cigna and local health care insurers or administrators. The program enhances quality and service by providing access to local health care administrators in selected countries while maintaining the benefits and advantages of a global plan. When you access care through a CignaLinks doctor or hospital, you will benefit from higher discounts and less paperwork.

If you are an employee who is on assignment, rotating, or you are a local national from a CignaLinks country, you will automatically be enrolled in the CignaLinks program. You may be required to fill out some additional paperwork. Cigna or Human Resources will contact you if this is necessary and will provide all the details.

CignaLinks networks are currently available in the United Kingdom, Canada, Australia, Hong Kong, the Middle East (Saudi Arabia, United Arab Emirates, Kuwait, Bahrain, Oman, and Qatar), Singapore, China, Macau, Indonesia, Taiwan, and Malaysia. Customers in China and Taiwan have access to the provider network in Hong Kong, and customers in Malaysia and Indonesia have access to the provider network in Singapore.

How does the Medical Program Work?

The Medical program offered through Cigna provides coverage both inside and outside the U.S. However, when seeking care inside the U.S., you will obtain greater cost savings by using a network provider. **It is your responsibility to verify the network status of the provider with Cigna each time you seek care.**

Remember...

Health care providers can move in and out of network at any time.

Out-of-Pocket Expenses and Your Bottom Line

When you receive medical care, you and the Medical program share the cost. This means that you'll pay deductibles and coinsurance according to the type of service you receive and the Medical program option you elect.

Deductibles

A deductible is an amount you must pay each Medical program year before the Medical program begins to share in the cost of covered services with you. Services received outside of the U.S. and U.S. in-network are not subject to a deductible. The Individual and Family deductibles for U.S. out-of-network services are as follows:

- Individual deductible: $1,000
- Family deductible: $2,000

Coinsurance

Coinsurance describes the cost-sharing between you and the program for eligible expenses. After you've satisfied your annual deductible, you and the Medical program share in the cost of eligible covered expenses. For example, after you've satisfied your annual deductible, you pay 20% coinsurance, and the program pays 80% coinsurance for in-network expenses in the U.S., up to program limits. When you stay in the network, the Medical program covers a higher percentage of the costs.

Out-of-pocket Maximum

This is the most you'll pay out of your own pocket (coinsurance and deductibles) in a year. Once you reach the out-of-pocket maximum, the program pays 100% of the eligible expenses for the rest of the year. The out-of-pocket maximum is combined for services received within and outside the U.S.

- International: $2,000 individual / $4,000 family
- US in-network: $2,000 individual / $4,000 family
- US out-of-network: $4,000 individual / $8,000 family

While deductibles and coinsurance count toward your out-of-pocket maximum, the following expenses do not apply toward the Cigna International out-of-pocket limits each year:

- Non-network expenses in the U.S.
- Charges that are not considered covered program expenses
- Amounts above the Eligible Expenses cost limit

Refer to the *Medical Schedule of Benefits* for more information.

Note: Deductibles and out-of-pocket maximums will accumulate between U.S. in-network, U.S. out-of-network, and international. All other plan maximums and service-specific maximums (dollar and occurrence) will also accumulate.

Annual and Lifetime Maximums

Certain services have an annual or lifetime maximum benefit allowed under the Medical program. An annual or lifetime maximum is the most the Medical program pays in benefits per person either per year or per lifetime, depending on the type of treatment or service. However, only eligible services are covered by the Medical program.

Important: For information on covered services, refer to the *Covered Expenses* and *Exclusions and Limitations* sections. Also, to confirm that the services you plan to receive are covered, request a pre-determination from Cigna.

Advocacy

A participant Advocacy service is available through the Baker Hughes Benefits Center. The Advocacy service assists you with access or claim issues that you have not been able to resolve after initial contact with the Claims Administrator's customer service. The participant Advocacy service is available for the following benefit programs:

- Medical
- Prescription Drug
- Dental
- Vision

Call the **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.) for more information.

Medical Schedule of Benefits

For information on covered services shown in the Medical Schedule of Benefits, including exclusions and limitations, refer to the *Covered Expenses* section and the *General Exclusions, Expenses Not Covered, and Limitations* section of this document. To confirm that the services you plan to receive are covered, request a pre-determination from Cigna's Care Coordination Unit.

Certain covered expenses are subject to day, visit, or dollar limits. All maximums are combined whether network, non-network, or outside the U.S.

Benefit Details	International	U.S. In-network	U.S. Out-of-network
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Percentage of covered expenses the program pays	100% of the maximum reimbursable charge	80%	60% of maximum reimbursable charge
Maximum Reimbursable Charge* The maximum reimbursable charge is based on the lesser of: • The provider's normal charge for a similar service or supply, or • A percentage of charges made by providers of such service or supply in the geographic area where the service is received.	N/A	N/A	150%
Maximum Reimbursable Charge Outside the United States* The maximum reimbursable charge is based on the lesser of: • The provider's normal charge for a similar service or supply, or • A percentage of charges made by providers of such service or supply in the geographic area where the service is received.	100%	N/A	N/A
Calendar Year Deductible			
• Individual	$0 per person	$0 per person	$1,000 per person
• Family maximum Family members meet only their individual deductible before the program pays coinsurance for their claims. Once the family deductible has been met, the plan coinsurance will be applicable for all covered family members.	$0 per family	$0 per family	$2,000 per family

Benefit Highlights	International	U.S. In-network	U.S. Out-of-network
Combined Annual Out-of-Pocket Maximum for Medical/Pharmacy/Vision			
• Individual	$2,000 per person	$2,000 per person	$4,000 per person
• Family maximum	$4,000 per family	$4,000 per family	$8,000 per family
Includes deductible. Family members meet only their individual out-of-pocket maximum before the program pays their claims at 100%. Once the family out-of-pocket maximum has been met, the program pays 100% for all covered family members' claims.			
Emergency Medical Evacuation & Repatriation Benefit maximum: Unlimited • Emergency medical evacuation • Repatriation following a medical evacuation • Repatriation of mortal remains • Emergency family travel arrangements and confinement visitation • Return of dependent children	100%	100%	100%
Physician's Services • Physician office visit • Consults and referrals • Surgery performed in the physician's office • Second Opinion Consultations (provided on a voluntary basis) • Allergy treatment	100%	80%	60% of maximum reasonable charge after deductible
Telemedicine	100%	80%	60% of maximum reasonable charge after deductible
Preventive Care (all ages) • Routine preventive care • Immunizations • Travel immunizations	100%	100%	100% no deductible
Lead Poisoning Screening Tests For children under age 6	100%	100%	60% of maximum reasonable charge after deductible

Benefit Highlights	International	U.S. In-network	U.S. Out-of-network
Mammograms, PSA, PAP Smear, and Colorectal Cancer Screenings			
• Routine preventive care	100%	100%	100% no deductible
• Diagnostic services	100%	80%	60% of maximum reasonable charge after deductible
Inpatient Hospital – Facility Services			
• Semi-private room and board	Limited to the semi-private room rate	Limited to negotiated semi-private room rate	Limited to semi-private room rate
• Private room	Limited to the semi-private room rate (Outside the U.S., private room covered only if no semi-private room equivalent available)	Limited to negotiated semi-private room rate	Limited to negotiated semi-private room rate
• Special care units (ICU/CCU)	Limited to ICU/CCU daily room rate	Limited to negotiated rate	Limited to negotiated semi-private room rate
Outpatient Facility Services Operating room, recovery room, procedures room, treatment room, and observation room	100%	80%	60% of maximum reasonable charge after deductible
Inpatient Hospital Physician's Visits/Consultations	100%	80%	60% of maximum reasonable charge after deductible
Inpatient Professional Services Surgeon, radiologist, pathologist, anesthesiologist	100%	80%	60% of maximum reasonable charge after deductible
Outpatient Professional Services Surgeon, radiologist, pathologist, anesthesiologist	100%	80%	60% of maximum reasonable charge after deductible
Urgent Care and Emergency Services ***Urgent Care Facility*** Includes Outpatient Professional Services X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit) Services billed as Emergency Services by an Urgent Care provider will be payable at the In-Network level. Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) billed by the facility as part of the UC visit.	80%	60%	60% of maximum reasonable charge after deductible

Benefit Highlights	International	U.S. In-network	U.S. Out-of-network
Emergency Services Hospital Emergency Room Includes Outpatient Professional Services and X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit) Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) billed by the facility as part of the ER visit	100%	80%	80% no deductible
Air Ambulance	100%	100%	100% after deductible
Ambulance	100%	100%	100% of maximum reasonable charge after deductible
Inpatient Services at Other Health Care Facilities Includes skilled nursing facility, rehabilitation hospital and subacute facilities (120-day limit per calendar year)	100%	80%	60% of maximum reasonable charge after deductible
Laboratory Services • Physician office visit • Outpatient facility • Laboratory services at an independent lab facility	100%	80%	60% of maximum reasonable charge after deductible
Radiology Services • Physician office visit • Outpatient facility	100%	80%	60% of maximum reasonable charge after deductible
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT scans, PET scans, etc.) • Physician office visit • Inpatient facility • Outpatient facility	100%	80%	60% of maximum reasonable charge after deductible

Benefit Highlights	International	U.S. In-network	U.S. Out-of-network
Outpatient Therapy Services Physician offer visit and outpatient hospital facility Includes: • Speech therapy • Occupational therapy • Pulmonary rehab • Cognitive therapy Unlimited combined calendar year maximum for all therapies	100%	80%	60% of maximum reasonable charge after deductible
Outpatient Physical/Physio Therapy Physician office visit and outpatient hospital facility Calendar year maximum: Unlimited	100%	80%	60% of maximum reasonable charge after deductible
Outpatient Cardiac Rehabilitative Therapy Physician office visit and outpatient hospital facility Calendar year maximum: Unlimited	100%	80%	60% of maximum reasonable charge after deductible
Chiropractic Care Physician office visit Calendar year maximum: Unlimited	100%	80%	60% of maximum reasonable charge after deductible
Home Health Care Services 120 visits per calendar year (includes outpatient private nursing when approved as Medically Necessary) The limit is not applicable to Mental Health and Substance Abuse Disorder conditions.	100%	80%	60% of maximum reasonable charge after deductible
Hospice • Inpatient services • Outpatient services	100%	80%	60% of maximum reasonable charge after deductible
Bereavement Counseling Provided as part of Hospice Care			
• Inpatient	100%	80%	60% of maximum reasonable charge after deductible
• Outpatient Services provided by mental health professional are covered under the Metal Health Benefit	100%	80%	60% of maximum reasonable charge after deductible

Benefit Highlights	International	U.S. In-network	U.S. Out-of-network
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medicially Necessary. Gene therapy must be received at an in-network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other in-network facilities is not covered.			
• Gene Therapy Product	Covered the same as medical pharmaceuticals	Covered the same as medical pharmaceuticals	Not covered
• Inpatient facility	100%	80%	Not covered
• Outpatient facility	100%	80%	Not covered
• Travel Maximum Available only for travel when prior authorized to receive gene therapy at a participating in-network facility specifically contracted with Cigna to provide the specific gene therapy.	$10,000 per episode of gene therapy	$10,000 per episode of gene therapy	Not covered
Maternity Care Services • Initial visit to confirm pregnancy • All subsequent prenatal visits, postnatal visits and physician's delivery charges (i.e., global maternity fee) • Physician office visits (In addition to the global maternity fee when performed by an OB/GYN or specialist) • Delivery facility (Inpatient hospital, birthing center)	100%	80%	60% of maximum reasonable charge after deductible
Abortion Elective and non-elective procedures • Physician office visit • Inpatient facilitylets • Outpatient facility	100%	80%	60% of maximum reasonable charge after deductible

Benefit Highlights	International	U.S. In-network	U.S. Out-of-network
Women's Family Planning Services • Office visits and counseling • Lab and radiology tests **Note:** Includes coverage for contraceptive devices (e.g., Depo-Provera and intrauterine devices (IUDs) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office. **Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)**	100%	100%	100% of maximum reasonable charge
• Physician office visit	100%	100%	100% of maximum reasonable charge after deductible
• Inpatient facility	100%	100%	100% of maximum reasonable charge after deductible
• Outpatient facility	100%	100%	100% of maximum reasonable charge after deductible
Men's Family Planning Services • Office visits and counseling • Lab and radiology tests **Surgical Sterilization Procedures for Vasectomy (excludes reversals)** • Physician office visit • Inpatient facility • Outpatient facility	100%	80%	60% of maximum reasonable charge after deductible

Infertility Services

Coverage will be provided for the following services:

- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).
- Artificial Insemination.
- Cryopreservation, storage, and thawing of sperm, eggs, embryos, and ovarian and testicular tissue.
- In-vitro.
- GIFT, ZIFT, etc.

Benefit Highlights	International	U.S. In-network	U.S. Out-of-network
Infertility Services • Physician office visit and counseling • Lab and radiology tests • Inpatient facility • Outpatient facility	100%	80%	60% of maximum reasonable charge after deductible
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants			
• Physician office visit	100%	80%	60% of maximum reasonable charge after deductible
• Inpatient facility	100%	80%	60% of maximum reasonable charge after deductible
• Lifetime travel maximum	Not covered	$10,000 (only when using a LifeSOURCE facility)	Not covered
Durable Medical Equipment Calendar year maximum: Unlimited	100%	80%	60% of maximum reasonable charge after deductible
External Prosthetic Appliances Calendar year maximum: Unlimited	100%	80%	60% of maximum reasonable charge after deductible
Hearing Exam Includes hearing exams, diagnosis, testing, and fitting of hearing aid devices One examination per 24-month period	100%	80%	60% of maximum reasonable charge after deductible
Hearing Aids One hearing aid necessary for each hearing impaired ear up to $1,000 per hearing aid every 3 years for a dependent child under age 24	100%	80%	60% of maximum reasonable charge after deductible
Diabetic Equipment (unlimited) • Insulin pump • Blood glucose monitor	100%	80%	60% of maximum reasonable charge after deductible
Wigs (for hair loss due to alopecia areata) • Calendar year maximum: $500	100%	80%	60% of maximum reasonable charge after deductible

Benefit Highlights	International	U.S. In-network	U.S. Out-of-network
Nutritional Counseling Up to three visits per calendar year. Three-visit limit does not apply to treatment of diabetes or to mental health and substance abuse disorder conditions. • Physician office visit • Inpatient facility • Outpatient facility	100%	80%	60% of maximum reasonable charge after deductible
Nutritional Formulas	100%	80%	60% of maximum reasonable charge after deductible
Genetic Counseling Up to three visits per calendar year for genetic counseling for both pre- and post-genetic testing. Three-visit limit does not apply to treatment of mental health and substance abuse disorder conditions. • Physician office visit • Inpatient facility • Outpatient facility	100%	80%	60% of maximum reasonable charge after deductible
Dental Care (from an injury) Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. • Physician office visit • Inpatient facility • Outpatient facility	100%	80%	60% of maximum reasonable charge after deductible
TMJ Surgical and Non-Surgical Includes appliance and excludes orthodontic treatment. Subject to medical necessity. Lifetime maximum (includes office visits, surgery, X-rays/advanced radiological imaging, and appliances): $1,000			
TMJ Treatment	100%	80%	60% of maximum reasonable charge after deductible
Dental Services for Children with Severe Disabilities Medically necessary specialized treatment and support to secure effective access to dental care for children under age 21 with severe disabilities will be provided at the in-network benefit level.			

Benefit Highlights	International	U.S. In-network	U.S. Out-of-network
Obesity/Bariatric Surgery Coverage is provided subject to medical necessity and clinical guidelines and is subject to any exclusions or limitations described elsewhere in this document. Contact Cigna prior to incurring such costs. • Physician office visit • Inpatient facility • Outpatient facility Lifetime maximum: $10,000 (applies to surgical procedure) **Notes:** • Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc. • Only surgical services accumulate to the maximum.	100%	80%	60% of maximum reasonable charge after deductible
Acupuncture Medically necessary treatment of pain or disease by acupuncture provided on an outpatient basis Calendar year maximum: Unlimited	100%	80%	60% of maximum reasonable charge after deductible
Alternative Therapies and Non-traditional Herbalist, massage therapist, naturopath Physician office visit Combined calendar year maximum: $1,000	100%	Not covered	Not covered

Routine Foot Disorders

Not covered except for services associated with foot care for diabetes, peripheral neuropathies, and peripheral vascular disease when medically necessary.

Treatment from Life Threatening Emergencies

Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.

Benefit Highlights	International	U.S. In-network	U.S. Out-of-network
Mental Health • Inpatient facility (includes acute and residential treatment) • Outpatient (includes office visits, individual, family, and group psychotherapy, medication management) • Outpatient – all other services (includes partial hospitalization, intensive outpatient services) Calendar year maximum: Unlimited	100%	80%	60% of maximum reasonable charge after deductible
Substance Abuse • Inpatient (includes acute inpatient detoxification and acute inpatient rehabilitation and residential treatment) • Outpatient (includes office visits, individual, family, and group psychotherapy, medication management) • Outpatient – all other services (includes partial hospitalization, intensive outpatient services) Calendar year maximum: Unlimited	100%	80%	60% of maximum reasonable charge after deductible

* The provider may bill you for the difference between its normal charge and the maximum reimbursable charge, in addition to applicable deductibles and coinsurance.

Emergency Care

In an emergency, you should get the treatment you need. If considered to be a true emergency by Cigna, the Claims Administrator, the Medical program pays according to the network schedule of benefits, regardless of the facility you go to.

Within the U.S., applicable non-network coinsurance will apply after the deductible has been satisfied.

Definition: A True Emergency means a serious medical condition or symptom resulting from injury, sickness, or mental illness that arises suddenly and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Preventive Health Services

The Baker Hughes Medical program network benefits are designed to encourage you, your spouse, and your eligible dependents to have routine, preventive checkups. Preventive health services provided under the Medical program are summarized below.

- Preventive health services received from a network provider are covered at 100%.
- No calendar year deductible applies and no other cost-sharing requirement (such as a copay or coinsurance) applies to preventive health services received from a network provider under those plans.
- The benefit includes the costs of services and tests performed during a wellness office visit with a network or out-of-area provider.

Medical program options may impose some cost-sharing requirements in connection with preventive health services.

- If the preventive health service is billed or tracked separately from an office visit, the Medical program may impose cost-sharing requirements with respect to the office visit.
- If the preventive health service is delivered during an office visit and the primary purpose of the office visit is not for the delivery of the preventive health service, the Medical program may impose cost-sharing requirements with respect to the office visit.
- If you receive preventive health services from a non-network provider, the benefit will be limited to 60% of the Covered Expense costs for the preventive health service after you meet the program's annual deductible.

Preventive health services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, or have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved to the extent such recommendations are considered current under regulations and guidance issued by the Department of Labor and other governmental agencies. A listing of these covered services can be found online at **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendation**s/.

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention).

A list of the immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention can be found online as follows:

- For persons aged 0 through 18: **http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf**
- For persons aged 19 or older: **http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf**
- For persons aged 4 months through 18 years who start late or who are more than one month behind: **http://www.cdc.gov/vaccines/schedules/downloads/child/catchup-schedule-pr.p**df
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. A list of these services can be found at: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=3**.
- With respect to women, to the extent not described in the first bullet, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. A list of these services can be found at: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=2**.

The following preventive health services are provided to women under the Medical program:

- **Gestational diabetes screening:** This screening is for women who are 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
- **HPV DNA testing:** Women who are 30 or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of Pap smear results.
- **HIV screening and counseling:** Sexually active women will have access to annual counseling on HIV.
- **STI counseling:** Sexually active women will have access to annual counseling on sexually transmitted infections (STIs).
- **Contraception and contraceptive counseling:** Women will have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. These recommendations do not include abortifacient drugs.
- **Breastfeeding support, supplies, and counseling:** Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment

  Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME provider or physician.

If more than one breast pump can meet your needs, benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

— Which pump is the most cost-effective;

— Whether the pump should be purchased or rented;

— The duration of a rental; and

— The timing of an acquisition.

- **Interpersonal and domestic violence screening and counseling:** Screening and counseling for interpersonal and domestic violence should be provided for all adolescent and adult women.

When a new recommendation or guideline is issued by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration and becomes effective, the Medical program will provide coverage for the new recommendation or guideline beginning with the plan year that starts on or after the date that is one year after the date the recommendation or guideline is issued and becomes effective.

When a recommendation or guideline is deleted from the current recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration, the Medical program will stop providing coverage for that recommendation or guideline to the extent allowed by applicable law.

Examples of preventive health services are listed below:

- Well woman, well man, or well child exam
- Prostate exam
- Diabetes screening
- Cholesterol check
- Tetanus-Diphtheria booster
- Flu shot (Influenza immunization)
- Blood pressure screening
- Colonoscopy (refer to *Medical Schedule of Benefits* for additional coverage details)

Preventive health services do not include diagnostic services or ongoing care related to a diagnosed condition. For a service to be covered under the Medical program as a preventive health service, the service must be for preventive care, not a diagnostic service.

Preventive health services will be provided under the Medical program in accordance with the requirements of, and subject to the limitations allowed under, the Patient Protection and Affordable Care Act (PPACA) and the Department of Labor and other governmental agency guidance issued thereunder. Applicable regulations allow the Medical program to use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service that constitutes a preventive health service. If the guidelines do not specify the applicable frequency, method, treatment, or setting for an item or service that constitutes a preventive health service, then the applicable frequency, method, treatment, or setting for such item or service shall be determined for purposes of the Medical program in accordance with generally accepted standards of medical practice.

What is a Diagnostic Service? Diagnostic services are services to diagnose a condition or treat a particular disease or condition that has been identified and may require ongoing or more extensive care.

Important: Preventive services are services that contribute to the prevention of a condition or disease. Diagnostic services are services to diagnose a condition or treat a particular disease or condition that has been identified and may require ongoing or more extensive care. Preventive health care is a screening and prevention benefit — it does not apply to diagnostic services or ongoing care related to a diagnosed condition. For a service to be covered under the preventive health service benefit provisions, the claim must be filed as routine preventive care, not diagnostic treatment.

Telemedicine

Telemedicine is a form of virtual health that allows you to see or talk to doctor from your mobile device or computer.

What's Covered by Cigna Global Health Benefits®

- Telemedicine services are covered at the same coverage level and cost share as the same service if rendered through in-person consultation or contact, subject to the same medical necessity criteria.
  - Must be provided by an appropriately licensed and credentialed health care professional (including primary care physicians and mental health professionals, etc.).
  - Coverage is provided per the terms and conditions of the policy and the health care professional's or vendor's contracting status: In- or out-of-network.
- Health care professionals, such as mental health professionals, primary care physicians, etc., may provide consultations via telemedicine.
- Telemedicine vendors, such as MDLIVE, Relay for Health, AmWell, etc., provide services for minor, non-urgent conditions.

Eligibility and Access

Third Country Nationals (non-U.S. employees on assignment in a country other than the U.S.) and U.S. expatriates (U.S. employees on assignment outside the U.S.) are eligible. This is how you can access services:

- Access services from any health care professional inside or outside the U.S. – home country or locally via web, email, phone, etc.
- Be aware of potential treatment limitations (including prescriptions) when seeking services from a remote health care professional.
- Access services from a local telemedicine vendor for minor, non-urgent care.

For employees not located in the U.S., we do not recommend seeking services from a U.S. telemedicine vendor due to licensing regulations and treatment limitations.

Nutrition Counseling

The Medical program also provides a nutrition counseling benefit. Participants may receive up to three nutrition counseling sessions per calendar year (this limit applies to non-preventive nutritional counseling services only). Coverage details for each Medical program option are provided in the *Medical Schedule of Benefits*.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for any other illness. Payment for pregnancy-related expenses will not be withheld because the pregnancy occurred before coverage took effect. Federal law prohibits the Medical program from:

- Limiting the length of a hospital stay for you and your newborn child to less than 48 hours following a vaginal delivery or 96 hours following a Caesarean delivery (if you're discharged earlier, the Medical program will pay for two post-delivery home visits by a health care provider);
- Requiring a provider to obtain authorization from the Medical program for prescribing any length of stay described above;
- Denying mother or newborn eligibility or continued eligibility to enroll or re-enroll for coverage just to avoid legal requirements;

- Making financial payments or rebates to mothers to encourage them to accept a shorter stay than described above;
- Providing financial incentives to the provider to encourage him or her to provide care inconsistent with current law; and
- Restricting benefits for any portion of such hospital stay to be less than benefits for any stay prior to the birth. However, if the mother chooses, she and the newborn may be released earlier.

Newborn Coverage

Any dependent child born while you are insured will become insured on the date of his or her birth if you elect dependent insurance no later than 60 days after his birth. If you do not elect to insure your newborn child within such 60 days, coverage for that child will end on the 60th day. No benefits for expenses incurred beyond the 60th day will be payable.

Contact the **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.) to enroll your newborn. You will be required to provide dependent verification documents.

Immunizations

Preventive adult and child immunizations received in-network are covered by the Medical program at 100% (no deductible applies). Preventive immunizations required for travel are also covered at 100% when received in-network. Your provider may bill you for the office visit or the cost to administer the immunizations if services other than the immunizations are provided. If immunizations are billed as preventive health care, they will be covered by the Medical program at 100%.

Immunizations received from a non-network provider are paid according to the *Medical Schedule of Benefits*.

Pre-Existing Conditions

The Medical program administered through Cigna does not have any pre-existing condition limitations. For information on covered expenses, refer to the *Medical Schedule of Benefits* and the *Covered Expenses* and *Exclusions and Limitations* sections.

How to File a Claim

There is no paperwork for U.S. in-network care. Just show your ID card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. U.S. out-of-network and international claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form. You may get the required claim form at **www.cignaenvoy.com** or from your benefit plan administrator. All fully completed claim forms and bills should be sent directly to your Cigna Service Center.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

Claim Reminders

- Be sure to use your group and account number when you file Cigna's claim forms or when you call the Cigna Service Center.
- Your account/group number are shown on your ID card.
- Be sure to follow the instructions listed on the back of the claim form carefully when submitting a claim to Cigna.

Claims must be Filed on a Timely Basis

Cigna will consider claims for coverage under its plans when proof of loss (a claim) is submitted within one year (365 days) for U.S. out-of-network and international benefits after services are rendered. If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last date of service. If claims are not submitted within one year for U.S. out-of-network and international benefits, the claim will not be considered valid and will be denied.

Important: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information — or conceals for the purpose of misleading — information concerning any material fact thereto, commits a fraudulent insurance act.

Covered Expenses

Covered expenses are charges for services covered by the Medical program for a covered individual, for the charges listed below for:

- Preventive care services, and
- Services or supplies that are medically necessary for the care and treatment of an injury or a sickness, as determined by Cigna and that are not otherwise excluded from coverage, and
- As determined by Cigna, medically necessary covered expenses may also include charges for generally accepted medical standards of care and practice.

As determined by Cigna, covered expenses may also include all charges made by a provider that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below.
Any applicable deductibles or limits are shown in the Medical Schedule of Benefits.

Covered expenses include:

- Inpatient hospital charges for bed and board and other necessary services and supplies that do not exceed the daily bed and board limit shown in the Schedule of Benefits
- Ambulance service to the nearest hospital where the needed medical care and treatment can be provided
- Hospital charges for outpatient medical care and treatment
- Free-standing surgical facility charges for medical care and treatment
- Other health care facility charges (including skilled nursing facility charges, rehabilitation hospital charges, or subacute facility charges) for medical care and treatment that do not exceed the Other Health Care Facility daily limit shown in the Schedule of Benefits
- Emergency services
- Urgent care
- Professional services provided by a physician or a psychologist
- Professional nursing service that is not performed by a family member
- Charges for anesthesia; diagnostic x-rays and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; and oxygen and other gases
- Foot care for diabetes, peripheral neuropathies, and peripheral vascual disease
- Laboratory services, radiation therapy, and other diagnostic and therapeutic radiological procedures
- Family planning costs, including a medical history, physical exam, related laboratory tests, medical supervision, other medical services, information and counseling on contraception, and implanted/injected embryos
- Contraceptives and medical services connected with surgical therapies (tubal ligations, vasectomies)
- The following preventive care services (see more information at **www.healthcare.gov**):
  - "A" or "B" rated recommendations according to the U.S. Preventive Services Task Force
  - Immunizations currently recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
  - Preventive care and screenings for infants, children, and adolescents as supported by the American Academy of Pediatrics and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders
  - Preventive care and screenings for women as supported by the Health Resources and Services Administration
- A baseline mammogram for asymptomatic women 35 and over; a mammogram every one or two years for asymptomatic women ages 40-49 beginning two years after a woman's baseline mammogram; an annual mammogram for women 50 and over; and any mammogram prescribed by a physician

- Travel immunizations
- Surgical or nonsurgical treatment of TMJ dysfunction
- One baseline lead poison screening test for dependent children at or around 12 months of age and lead poison screening and diagnostic evaluation for dependent children under the age of 6 who are at high risk for lead poisoning according to guidelines set by the Division of Public Health
- Immunization for children from birth through age 18 against diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, Haemophilus influenzae B, and hepatitis A
- U.S. FDA-approved prescription contraceptive drugs and devices and outpatient contraceptive services including consultations, exams, procedures, and medical services related to the use of contraceptives and devices
- Diabetic supplies as ordered by a participating physician or other participating health care professional, including insulin pumps and blood glucose meters
- Scalp hair prostheses worn due to alopecia areata
- Colorectal cancer screening for persons 50 or older or those at high risk of colon cancer because of:
  - Family history of familial adenomatous polyposis
  - Family history of hereditary nonpolyposis colon cancer
  - Chronic inflammatory bowel disease
  - Family history of breast, ovarian, endometrial, colon cancer, or polyps
  - A background, ethnicity or lifestyle that the health care provider believes puts the patient at elevated risk

  Coverage will include screening with an annual fecal occult blood test, flexible sigmoidoscopy or, or radiologic imaging or other screening modalities as supported by the Secretary of Health and Social Services of Delaware after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, and the U.S. Preventive Task Force Services for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending physician. Also included is the use of anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with generally accepted standards of medical practice and all applicable patient safety laws and regulations, if deemed medically necessary by the treating physician.
- Hearing aids (every 3 years) for dependent children up to age 24
- Nutritional formulas, low protein modified foods or other medical food consumed or administered enterally (via tube or orally) that are medically necessary for the treatment of inherited metabolic diseases, such as phenylketonuria (PKU), maple syrup urine disease, urea cycle disorders, tyrosinemia, and homocystinuria, when administered under the direction of a physician

- The following care and assistive communication devices prescribed for an individual diagnosed with autism spectrum disorder by a licensed physician or psychologist:
  - Behavioral health treatment
  - Pharmacy care
  - Psychiatric care
  - Psychological care
  - Therapeutic care
  - Items and equipment necessary to provide, receive, or advance in the above-listed services, including those necessary for applied behavioral analysis
  - Any care for individuals with autism spectrum disorders that is determined by the Secretary of the Department of Health and Social Services to be medically necessary
- An annual Papanicolaou laboratory screening (PAP) test
- An annual prostate-specific antigen test (PSA)
- CA-125 monitoring of ovarian cancer after treatment for ovarian cancer, not including routine screening
- Hearing loss screening tests of newborns and infants provided by a hospital before discharge

Clinical Trials

This Medical program covers routine patient care costs and services related to an approved clinical trial for a qualifed individual who meets the following requirements:

- Is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition, and
- Either
  - The referring health care professional is a participating health care provider and has concluded that the individual meets the conditions described in the first bullet, or
  - The individual provides medical and scientific information that the individual meets the conditions described in the first bullet

For purposes of clinical trials, the term “life-threatening disease or condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements. The study or investigation must:

- Be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- Involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care, including drugs, items, devices, and services covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- Services required solely for the provision of the investigational drug, item, device, or service;
- Services required for the clinically appropriate monitoring of the investigational drug, device, item, or service;
- Services to prevent complications from the provision of the investigational drug, device, item, or service;
- Reasonable and necessary care arising from the provision of the investigational drug, device, item, or service, including the diagnosis or treatment of complications; and
- Routine patient care costs (as defined) for covered persons engaging in clinical trials for the treatment of life threatening diseases.

Examples of routine patient care costs and services include:

- Radiological services
- Laboratory services
- Intravenous therapy
- Anesthesia services
- Physician services
- Office services
- Hospital services
- Room and board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial

Routine patient care costs and services do **not** include:

- The investigational drug, item, device, or service itself, or that is provided solely to satisfy data collection and analysis needs.
- Items or services not used in the direct clinical management of the individual;
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items or services provided by the research sponsors free of charge for any person enrolled in the trial.
- Travel and transportation expenses, unless otherwise covered under the plan, including but not limited to fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train; mileage reimbursement for driving a personal vehicle; lodging; and meals.
- Routine patient costs obtained out-of-network when out-of-network benefits do not exist under the plan.

If your program includes in-network providers, clinical trials conducted by non-participating providers will be covered at the in-network benefit level if:

- There are not in-network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- The clinical trial is conducted outside the individual's state of residence.

Genetic Testing

This Medical program covers charges for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable diseases only if:

- The person has symptoms or signs of a genetically-linked inheritable disease;
- The person has been determined to be at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- The therapeutic purpose is to identify a specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options

Pre-implantation genetic testing (genetic diagnosis prior to embryo transfer) is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to three visits per calendar year for both pre- and post-genetic testing.

Nutritional Counseling

The costs of nutritional counseling are covered when diet is a part of the medical management of a medical or behavorial condition.

Enteral Nutrition

Coverage includes medically approved formulas and medical foods that are specially formulated for enteral feedings or oral consumption, low protein modified formulas and modified food products, consumed, or administered enterally (via tube or orally), which are medically necessary as prescribed by a physician for treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism), and the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), when administered under the direction of a physician.

Internal Prosthetic/Medical Appliances

Charges for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically necessary repair, maintenance, or replacement of a covered appliance is also covered.

Alternative Therapies and Non-traditional Medical Services – Outside the U.S.

Charges for alternative therapies and non-traditional medical services are limited to the amount shown in the Schedule of Benefits. Alternative therapies and non-traditional medicine include services provided by an herbalist, naturopath, or massage therapist, when these services are provided for a covered condition outside the U. S. in accordance with customary local practice and the practitioner is operating within the scope of his/her license, and the treatment is medically necessary, cost-effective, and provided in an appropriate setting.

Obesity Treatment

Clinically severe, or morbid, obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without secondary illnesses (comorbidities), or a BMI of 35-39 with secondary illnesses (comorbidities). Medical and surgical services for the treatment of morbid obesity are covered if they are scientifically demonstrated to be safe and effective.

Exclusions and Limitations

The following items are specifically excluded:

- Medical and surgical services to alter appearances or physical changes resulting from the treatment or control of obesity, and
- Weight loss programs or treatments even if prescribed by a physician or performed under medical supervision.

Orthognathic Surgery

Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct is covered provided:

- The deformity or disfigurement is accompanied by a documented clinically significant functional impairment and there is a reasonable expectation that the procedure will result in meaningful functional improvement;
- The orthognathic surgery is medically necessary as a result of tumor, trauma, or disease; or
- The orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review physician.

Home Health Services

This Medical program pays for home health services when you require skilled care, are unable to obtain the required care as an ambulatory outpatient, and do not require admission to a hospital or other health care facility.

Home health services are covered only if Cigna has determined that the home is a medically appropriate setting. If you are dependent upon others for non-skilled care and/or custodial services (e.g., bathing, eating, toileting), home health services will be provided for you only when there is a family member or caregiver present in the home to meet your non-skilled care and/or custodial services needs.

Skilled home health services can be provided during a visit by another health care professional. A visit is defined as a period of two hours or less. The services of a home health aide are covered when given in support of skilled health care services provided by other health care professionals. Home health services are subject to a maximum of 16 hours in total per day. Necessary medical supplies and home infusion therapy used by other health care professionals in providing home health services are covered. Services performed by a member of your family or your dependent's family or a person who normally resides in your house or your dependent's house are not covered, even if that person is another health care professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other short-term rehabilitative therapy services provided in the home are subject to the benefit limitations shown in the *Short-Term Rehabilitative Therapy* section, not *Home Health Services*.

Hospice Care Services

The following hospice care services are covered for a person diagnosed as having twelve months or fewer to live due to terminal illness:

- Room and board and services and supplies provided by a hospice facility
- Outpatient services provided by a hospice facility
- Professional services provided by a physician
- Individual and family counseling provided by a psychologist, social worker, family counselor, or ordained minister
- Pain relief treatment, including drugs, medicines, and medical supplies
- Services provided by any other health care facility for:
  - Part-time or intermittent nursing care by or under the supervision of a nurse
  - Part-time or intermittent services of any other health care professional
- Physical, occupational, and speech therapy
- Medical supplies, drugs, and medicines lawfully dispensed on the written prescription of a physician an laboratory services that would have been covered for a patient in a hospital or hospice facility

Exclusions and Limitations

The following hospice care services are not covered:

- Services provided by a family member or a dependent's family member, or by a person who normally lives in your house or your dependent's house
- Services performed at any time the patient is not under a physician's care
- Services or supplies not listed in the hospice care program
- Curative or life-prolonging procedures
- Services for which benefits are payable under another part of your policy
- Services or supplies that primarily aid you in daily living

Mental Health and Substance Abuse Services

Mental health services are services that are required to treat a disorder that impairs behavior, emotional reaction, or thought processes. In determining benefits payable, charges for the treatment of any physiological conditions related to mental health will not be considered as charges for the treatment of mental health.

Substance abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges for the treatment of any physiological conditions related to rehabilitation services for substance abuse will not be considered as charges for the treatment of substance abuse.

Inpatient Mental Health Services

This program covers services provided by a hospital while you or your dependent is confined for mental health treatment and evaluation. Inpatient mental health services include partial hospitalization and mental health residential treatment services.

Partial hospitalization sessions are services that are provided for not less than four hours and not more than 12 hours in any 24-hour period.

Mental health residential treatment services are services provided by a hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute mental health conditions.

A mental health residential treatment center is an institution that specializes in the treatment of psychological and social disturbances that are the result of mental health conditions; provides a subacute, structured, psychotherapeutic treatment program under the supervision of physicians; provides 24-hour care in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a mental health residential treatment center when he or she is a registered bed patient in a mental health residential treatment center upon the recommendation of a physician.

Outpatient Mental Health Services

Outpatient mental health services are services offered by providers who are qualified to treat mental health on an outpatient basis — through individual, group, or mental health intensive outpatient therapy programs or partial hospitalization. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression that interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/ adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A mental health intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program.

Intensive outpatient therapy programs provide a combination of individual, family and/or group therapy in the same day for nine or more hours a week.

Inpatient Substance Abuse Rehabilitation Services

This program covers rehabilitation services, while you or your dependent is confined in a hospital, that are required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient substance abuse services include partial hospitalization sessions and residential treatment services.

Partial hospitalization sessions are services that are provided for not less than four hours and not more than 12 hours in any 24-hour period.

Substance abuse residential treatment services are services provided by a hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance abuse conditions.

A substance abuse residential treatment center is an institution that specializes in the treatment of psychological and social disturbances that are the result of substance abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a substance abuse residential treatment center when he or she is a registered bed patient in a substance abuse residential treatment center upon the recommendation of a physician.

Outpatient Substance Abuse Rehabilitation Services

This program covers services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs for you or your dependent while not confined in a hospital, including outpatient rehabilitation in an individual, group, or substance abuse intensive outpatient therapy program.

A substance abuse intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive outpatient therapy programs provide a combination of individual, family, and/or group therapy in the same day for a total of nine or more hours in a week.

Substance Abuse Detoxification Services

Detoxification and related medical services are covered when required to diagnose and treat addiction to alcohol and/or drugs. Cigna will decide, based on the medical necessity of each situation, whether these services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from coverage for mental health and substance abuse services:

- Treatment of disorders that have been diagnosed as organic mental disorders associated with permanent brain dysfunction
- Developmental disorders, including , but not limited to, reading, arithmetic, language, or articulation disorders
- Counseling for activities of an educational nature
- Counseling for borderline intellectual functioning
- Counseling for occupational problems
- Counseling related to consciousness raising
- Vocational or religious counseling
- I.Q. testing
- Custodial care, including but not limited to, geriatric day care
- Psychological testing of children requested by or for a school system
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline

Durable Medical Equipment

This program covers the purchase or rental of durable medical equipment for use outside of a hospital or other health care facility that is ordered or prescribed by a physician and provided by a vendor approved by Cigna. Coverage for repair, replacement, or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility.

Durable medical equipment is defined as items that are designed for and able to withstand repeated use by more than one person, serve a medical purpose, generally are not useful in the absence of injury or sickness, are appropriate for home use and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheelchairs, and dialysis machines.

Exclusions

Durable medical equipment items that are not covered include, but are not limited to, those listed below:

- **Bed-related items:** bed trays, over-the-bed tables, bed wedges, pillows, custom bedroom equipment, and mattresses including non-power mattresses, custom mattresses, and posturepedic mattresses
- **Bath-related items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand-held showers, paraffin baths, bath mats, and spas
- **Fixtures to real property:** ceiling lifts and wheelchair ramps
- **Car or van modifications**
- **Air quality items:** room humidifiers, vaporizers, air purifiers, and electrostatic machines
- **Other equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment, and diathermy machines

External Prosthetic Appliances and Devices

The Medical program covers the cost of the initial purchase and fitting of external prosthetic appliances and devices ordered by a physician that are available only by prescription and that are necessary to alleviate or correct an injury, a sickness, or a congenital defect.

External prosthetic appliances and devices include prostheses/prosthetic appliances and devices, orthoses and orthotic devices, braces, and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are fabricated replacements for missing body parts. They include, but are not limited to:

- Limb prostheses
- Terminal devices such as hands or hooks
- Speech prostheses
- Facial protheses

Orthoses and Orthotic Devices

Orthoses and orthotic devices are orthopedic appliances or apparatuses used to support, align, prevent, or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses is limited to only:
  - Rigid and semirigid custom-fabricated orthoses;
  - Semirigid prefabricated and flexible orthoses; and
  - Rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses is limited to only:
  - For patients with impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy and peripheral vascular disease);
  - When the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g., amputated toes) and is necessary for the alleviation or correction of injury, sickness, or congential defect; and
  - For patients with a neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot when there is reasonable expectation of improvement.

Exclusions

The following are specifically excluded orthoses and orthotic devices:

- Prefabricated foot orthoses
- Cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit.
- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications, and transfers
- Non-foot primarily used for cosmetic rather than functional reasons and non-foot orthoses primarily for improved athletic performance or sports participation

Braces

A brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and allows for motion of that part.

Braces are covered except for the Copes scoliosis brace, which is specifically excluded.

Splints

A splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for Replacement

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person using the appliance or device will not be covered.
- Replacement for anatomic change that has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy, and/or growth.

Coverage for replacement is limited as follows:

- No more than once every 24 months for persons 19 or older
- No more than once every 12 months for persons 18 or under
- When replacement is necessary because of a surgical alteration or revision of the site

Exclusions

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices
- Microprocessor controlled prostheses and orthoses
- Myoelectric prostheses peripheral nerve stimulators

Short-Term Rehabilitative Therapy

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation, and pulmonary rehabilitation therapy, will be covered when provided in the most medically appropriate setting. Occupational therapy is covered only when used to enable the patient to perform the activities of daily living after an illness, injury, or sickness.

Exclusions

Short-term rehabilitative therapy services that are not covered include:

- Sensory integration therapy, group therapy, treatment of dyslexia, behavior modification, or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia, or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury
- Maintenance or preventive treatment consisting of routine, long-term or non-medically necessary care provided to prevent recurrence or to maintain the patient's current status

Multiple outpatient services provided on the same day constitute one day.

Services that are provided by a chiropractic physician with respect to short-term rehabilitation therapy are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain, and improve function.

Chiropractic Care Services

Chiropractic Care Services include charges for diagnostic and treatment services utilized in an office setting by chiropractic physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic physicians. Multiple therapy services provided on the same day constitute one day of service for each therapy type.

Coverage is provided when medically necessary in the most medically appropriate setting to:

- Restore function (called "rehabilitative"):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of sickness, injury, or loss of a body part.

- Improve, adapt, or attain function (sometimes called "habilitative"):
  - To improve, adapt, or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the following criteria are met:

- The condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
- The therapy is medically necessary and medically appropriate for the diagnosed condition.

Coverage for occupational therapy is provided only for purposes of enabling individuals to perform the activities of daily living after an injury or sickness.

Exclusions

Chiropractic care services that are not covered include:

- Sensory integration therapy
- Treatment of dyslexia
- Maintenance treatment for therapy (other than physical therapy or Chiropractic Care) or preventive treatment provided to prevent recurrence or to maintain the patient's current status
- Charges for Chiropractic Care not provided in an office setting
- Vitamin therapy

Alternative Therapies and Non-Traditional Medical Services

Coverage for alternative therapies and non-traditional medical services are limited to $1,000 per calendar year. Alternative therapies and non-traditional medicine include services provided by an herbalist or naturopath, or for massage therapy when these services are provided for a covered condition outside the U.S. in accordance with customary local practice and when the practitioner is operating within the scope of his or her license and the treatment is medically necessary, cost-effective, and provided in an appropriate setting.

Breast Reconstruction and Breast Prostheses

Charges for reconstructive surgery following a mastectomy are covered. Benefits include:

- Surgical services for reconstruction of the breast on which surgery was performed
- Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance
- Postoperative breast prostheses
- Mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

Charges for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement that is accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder) are covered provided that the surgery or therapy restores or improves function; reconstruction is required as a result of medically necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review physician.

Transplant Services

Charges for human organ and tissue transplant services, which include solid organ and bone marrow/stem cell procedures, are covered. This coverage is subject to the following conditions and limitations:

- Transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement.
- Transplant services are covered only if they are required to perform any of the following human-to-human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas, or intestine that includes small bowel-liver or multi-visceral.
- Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.
- All transplant services and related specialty care services, other than cornea transplants, are covered when received at Cigna LifeSOURCE Transplant Network® facilities.
- Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those transplant services, other than CIGNA LIFESOURCE Transplant Network® facilities, are payable at the U.S. in-network level. Transplant services received at any other facilities, including non-participating providers and participating providers not specifically contracted with Cigna for transplant services, are covered at the out-of-network level.
- Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization, and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if medically necessary. Costs related to the search for, and identification of, a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services (U.S. In-Network Coverage Only)

Charges made for non-taxable travel expenses you incur in connection with a preapproved organ/ tissue transplant are covered subject to the following conditions and limitations:

- Transplant and related speciality care travel benefits are not available for cornea transplants.
- Benefits for transportation, lodging and food are available only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant-related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from, the transplant site; and food while at, or traveling to and from, the transplant site.

In addition to covering your charges for the items listed above, Cigna will also cover these charges for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses:

- Any expenses that if reimbursed would be taxable income;
- Travel costs incurred for travel within 60 miles of your home;
- Laundry bills;
- Telephone bills;
- Alcohol or tobacco products; and
- Charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

Medical Pharmaceuticals

The program covers medical pharmaceuticals that are administered in an inpatient setting, outpatient setting, physician's office, or in a covered person's home.

Benefits under this section are provided only for medical pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified physician or other health professional.

Benefits payable under this section include medical pharmaceuticals whose administration may initially, or typically, require physician or other health professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Certain medical pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain medical pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such medical pharmaceuticals, you are required to try a different medical pharmaceuticals and/or prescription drug product.

Step therapy does not apply to FDA approved cancer drugs for the treatment of stage 4 metastatic cancer or any other cancer.

Utilization management requirements or other coverage conditions are based on a number of factors which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety, or relative efficacy of medical pharmaceuticals as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the medical pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the medical pharmaceuticals and available rebates. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your dependents is a determination that is made by you (or your dependent) and the prescribing physician.

The coverage criteria for medical pharmaceuticals may change periodically for various reasons. For example, a medical pharmaceutical may be removed from the market, a new medical pharmaceutical in the same therapeutic class as a medical pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a medical pharmaceutical include, but are not limited to, an increase in the cost of a medical pharmaceutical.

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when medically necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- Replacing a disease-causing gene with a healthy copy of the gene.
- Inactivating a disease-causing gene that may not be functioning properly.
- Introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at in-network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

Gene therapy products and their administration are covered when prior authorized.

Gene Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating in-network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses:

- Any expenses, that if reimbursed, would be taxable income
- Travel costs incurred due to travel within 60 miles of your home
- Food and meals
- Laundry bills
- Telephone bills
- Alcohol or tobacco product
- Charges for transportation that exceed coach class rates

Emergency Medical Evacuation and Repatriation Benefits

Expenses incurred for evacuation or repatriation without the approval and authorization of Cigna, and/or its designee will not be covered expenses. Only those expenses approved by Cigna will be eligible for coverage and/or reimbursement under the terms of your plan.

If you or your dependent suffer a medical emergency and, Cigna, and/or its designee, determines that appropriate medical facilities are not available locally, Cigna may arrange for an evacuation to the nearest appropriate facility.

You or your dependent must contact Cigna at the phone number indicated on your ID card to begin this process. In making their determinations, Cigna, and/or its designee, will consider the nature of the emergency, your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train, or ambulance depending upon the medical needs and available transportation specific to the specific medical necessity of each case.

Repatriation Following a Medical Evacuation

Following any covered emergency medical evacuation, Cigna will pay for one of the following:

- If it is deemed medically necessary and appropriate by the Cigna medical director, you or your dependent will be transferred to your permanent residence via a one-way economy airfare; or
- You or your dependent will be transferred back to your original work location or the location from which you were evacuated via a one-way economy airfare.

If your transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna, and/or its designee, determines a mode of transport other than economy class seating on a commercial aircraft is required for Medical Necessity reasons, Cigna, or its designee, will arrange accordingly and such will be covered by Cigna.

Repatriation of Mortal Remains

The costs associated with the transportation of mortal remains from the place of death to the Home Country will be covered. In addition, assistance will be provided by Cigna, or its designee, for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

Emergency Family Travel Arrangements and Confinement Visitation

If Cigna determines that you or your Dependent is expected to require hospitalization in excess of 7 days at the location to which you will be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by you. If a dependent child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the dependent child is hospitalized. Only those expenses approved by Cigna and/or its designee prior to occurrence will be eligible for coverage and reimbursement under the terms of your plan.

Return of Dependent Children

If dependent child(ren) are left unattended by virtue of the evacuee's absence following a covered evacuation, a one-way economy airfare will be provided to their place of residence or that of an individual chosen by you.

Exclusions

No payment will be made for charges for:

- Services rendered without the authorization or intervention of Cigna, or its designee.
- Non-emergency routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to you.
- A condition which would allow for treatment at a future date convenient to you and which does not require emergency medical evacuation or repatriation.
- Medical care or services scheduled for a member or a providers convenience which are not considered an emergency.
- Expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment.
- Services provided for which no charge is normally made.
- Expenses incurred while serving in the armed forces of another country.
- Transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation.
- Services provided other than those indicated in this certificate.
- Housing/lodging or accommodations, meals or travel related expenses.
- Hotel and accommodations for covered Dependents post discharge or while awaiting fitness to fly approval.
- Expenses incurred in the U.S. are excluded, with the exception of:
  - Repatriation following a medical evacuation;
  - Primary repatriation to your permanent residence after a serious medical event; or
  - Repatriation of mortal remains.
- Injury or sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion, or police action.
- Death caused by war, or an act of war, whether declared or undeclared, riot, civil commotion, or police action.
- Claim payments that are illegal under applicable law.

General Exclusions and Expenses Not Covered

In addition to the coverage limitations shown in the *Medical, Dental, Vision, and Prescription Drug* sections, the following are also excluded from payment under your programs:

- Care for health conditions that are required by state or local law to be treated in a public facility
- Care required by state or federal law to be supplied by a public school system or school district
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available
- Services for or in connection with an injury or sickness that is due to war, declared or undeclared, riot, civil commotion, or police action that occurs in the employee's country of citizenship
- Claim payments that are illegal under applicable law
- Charges that you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this program
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing, or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary, or convalescent care
- Services for or in connection with experimental, investigational, or unproven services
- Unless otherwise covered in this program, charges for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses,

and court-ordered, forensic, or custodial evaluations

- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a physician and listed as covered in this program
- Medical and hospital care and costs for the infant child of a dependent, unless this infant child is otherwise eligible under this program
- Non-medical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, biofeedback, and neurofeedback
- Hypnosis, sleep therapy, employment counseling, back-to-school and return-to-work services, work hardening programs, driving safety, and services, training, educational therapy, or other non-medical ancillary services for learning disabilities, developmental delays, or mental retardation
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic, or recreational performance, including but not limited to routine, long-term, or maintenance care that is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, personal digital assistants (PDAs), Braille typewriters, visual alert systems for the deaf, and memory books except as shown in *Covered Expenses* for treatment of autism
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as otherwise included in your program
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery
- Blood administration for the purpose of general improvement in physical condition
- Cosmetics, dietary supplements, and health and beauty aids
- Medical treatment when payment is denied by a primary program because treatment was received from a nonparticipating provider
- Services for or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit
- Telephone, email, and Internet consultations and telemedicine

General Limitations

No payment will be made for expenses incurred for you or any one of your dependents:

- For charges made by a hospital owned or operated by, or that provides care or performs services for, the U.S. government, if such charges are directly related to a military service-connected injury or sickness
- To the extent that you or any one of your dependents is in any way paid or entitled to payment for those expenses by or through a public program other than Medicaid
- To the extent that payment is unlawful where the patient resides when the expenses are incurred
- For charges that would not have been made if the patient had no insurance
- To the extent that the expenses are more than the maximum reimbursable charges
- To the extent of the exclusions imposed by any certification requirement shown in this program
- For supplies, care, treatment, or surgery that are not medically necessary
- For charges made by any covered provider who is a member of your family or your dependent's family

Payment of Benefits – Medical

To Whom Payable

Medical benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a non-participating provider even if benefits have been assigned. When benefits are paid to you or your dependent, you or your dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to recover that overpayment from the person to whom or on whose behalf it was made, or offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- The methodologies in the most recent edition of the Current Procedural terminology, and
- The methodologies as reported by generally recognized professionals or publications.

Medical Benefits Extension

During Hospital Confinement Upon Policy Cancellation

If the medical benefits under this plan cease for you or your dependent due to cancellation of the policy (except if the policy is canceled for nonpayment of premiums) and you or your dependent is confined in a hospital on that date, medical benefits will be paid for Covered Expenses incurred in connection with that hospital confinement. However, no benefits will be paid after the earliest of:

- The date you exceed the maximum benefit, if any, shown in the Schedule;
- The date you are covered for medical benefits under another group plan;
- The date you or your dependent is no longer hospital confined; or
- 10 days from the date the policy is canceled.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy that exists when your medical benefits cease or your dependent's medical benefits cease.

Claim Determination Procedures Under ERISA

The following complies with federal law. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below.

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and you may appeal the determination. Appeal procedures are described in the certificate, in your provider's network participation documents, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a physician with knowledge of your health condition, cause you severe pain that cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's physician will defer to the determination of the treating physician regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow Cigna's procedures for requesting a required preservice Medical Necessity determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request.

However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Postservice Claim Determinations

When you or your representative requests payment for services that have been rendered, Cigna will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal; upon request and free of charge, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied on in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment, or other similar exclusion or limit; information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

When You Have a Complaint or Appeal

> **Tip**
>
> File your claims on a timely basis and keep a copy of your claim forms, receipts, and all supporting evidence for your records.

For the purposes of this section, any reference to “you,” “your,” or “member” also refers to a representative or provider designated by you to act on your behalf unless otherwise noted.

Cigna’s “physician reviewers” are licensed physicians depending on the care, service or treatment under review.

Cigna has established a process for addressing your concerns and solving your problems.

Start With Member Services

If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your ID card, explanation of benefits, or claim form and explain your concern to one of Cigna’s member services representatives. You may also express that concern in writing. You can write to Cigna at the following address:

Cigna
Attn: Appeals Department
P.O. Box 15800
Wilmington, DE 19850

Cigna will do its best to resolve the matter on your initial contact. If more time is needed to review or investigate your concern, Cigna will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write Cigna at the toll-free number on your ID card, explanation of benefits, or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, Cigna will respond in writing with a decision within 15 calendar days after it receives an appeal for a required pre-service or concurrent care coverage determination, and within 30 calendar days after it receives an appeal for a post-service coverage determination. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health, or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain that cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level one appeal would be detrimental to your medical condition.

Cigna’s Physician Reviewer, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Requests for a level two appeal regarding the medical necessity or clinical appropriateness of your issue will be conducted by a committee, which consists of one or more people not involved in the prior decision. The committee will consult with at least one physician in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer. You may present your situation to the committee by conference call.

For required pre-service and concurrent care coverage determinations, the committee review will be completed within 15 calendar days; for post-service claims, the committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the committee to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the committee's decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the committee's decision so that you will have an opportunity to respond.

You will be notified in writing of the committee's decision within five business days after the committee meeting, and within the committee review time frames above if the committee does not approve the requested coverage.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health, or ability to regain maximum functionality; or, in the opinion of your physician, would cause you severe pain that cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient hospital stay. Cigna's Physician Reviewer, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. Cigna will abide by the decision of the Independent Review Organization.

To request a review, you must notify the appeals coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 45 days.

If an expedited review is requested and Cigna's Physician Reviewer determines that a delay would be detrimental to your medical condition, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services and you have not yet been discharged from a facility, the review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if it is an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA Section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment, or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

Relevant Information

Relevant information includes any document, record, or other information that: was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action. However, no action may be brought unless it is brought within three years after a claim is submitted for in-network services or within three years after proof of claim is required under the plan for out-of-network services.

Communications in Foreign Languages

In connection with the claims and appeals described above, to the extent required under Department of Labor and Department of Treasury regulations, the Claims Administrator will communicate with claimants in a culturally and linguistically appropriate manner. If a person filing a benefit claim or appeal resides in a United States county in which 10 percent or more of the population is literate in a Non-English language, as determined in guidance published by the Secretary of Labor or Department of Treasury (an "Applicable Non-English Language"), then in connection with such individuals' claims and appeals described above (1) the Claims Administrator will provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the Applicable Non-English Language and providing assistance with filing claims and appeals in the Applicable Non-English Language and (2) the Claims Administrator will provide, upon request, any notices in the Applicable Non-English Language and (3) the Claims Administrator will include in the English versions of all notices a statement prominently displayed in the Applicable Non-English Language clearly indicating how to access the language services provided by the Medical program.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Cigna, or if Cigna fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Cigna's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based on any of the following:

- Clinical reasons;
- The exclusions for experimental or investigational services or unproven services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Cigna's decision.

An external review request should include all of the following:

- A specific request for an external review;
- The covered person's name, address, and insurance ID number;
- Your designated representative's name and address, when applicable;
- The service that was denied; and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Cigna has entered into agreements with three or more IROs that have agreed to perform such reviews.

There are two types of external reviews available:

- A standard external review, and
- An expedited external review.

Important: A participant may not request an external review of a determination by Baker Hughes that the participant is not eligible to participate in and receive benefits under the Medical program.

Standard External Review

A standard external review comprises all of the following:

- A preliminary review by Cigna of the request;
- A referral of the request by Cigna to the IRO; and
- A decision by the IRO.

Within the applicable time frame after receipt of the request, Cigna will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided;
- Has exhausted the applicable internal appeals process; and
- Has provided all the information and forms required so that Cigna may process the request.

After Cigna completes the preliminary review, Cigna will issue a notification in writing to you. If the request is eligible for external review, Cigna will assign an IRO to conduct such review. Cigna will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review.

The IRO is not required to, but may, accept and consider additional information submitted by you after 10 business days.

Cigna will provide to the assigned IRO the documents and information considered in making Cigna's determination. The documents include:

- All relevant medical records;
- All other documents relied on by Cigna; and
- All other information or evidence that you or your physician submitted. If there is any information or evidence you or your physician wish to submit that was not previously provided, you may include this information with your external review request and Cigna will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Cigna. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and Cigna, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Cigna's determination, the plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final appeal decision, if the determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure, or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, Cigna will determine whether the individual meets both of the following:

- Is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided; and
- Has provided all the information and forms required so that Cigna may process the request.

After Cigna completes the review, Cigna will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Cigna will assign an IRO in the same manner Cigna utilizes to assign standard external reviews to IROs. Cigna will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Cigna. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to Cigna.

You may contact Cigna at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Coordination of Benefits

This section applies if you or any one of your dependents is covered under more than one plan and determines how benefits payable from all such plans will be coordinated. You should file all claims with each plan. For claims incurred within the United States, you should file all claims under each plan. For claims incurred outside the United States, if you file claims with more than one plan, you must indicate, at the time of filing a claim under this plan, that you also have or will be filing your claim under another plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical, dental or vision care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured that neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage;
- Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies; and
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each plan or part of a plan that has the right to coordinate benefits will be considered a separate plan.

Closed Panel Plan

A plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The plan that determines and provides or pays benefits without taking into consideration the existence of any other plan.

Secondary Plan

A plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the primary plan. A secondary plan may also recover from the primary plan the reasonable cash value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance, or copayments, that is covered in full or in part by any plan covering you. When a plan provides benefits in the form of services, the reasonable cash value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the plans is not an Allowable Expense;
- If you are confined to a private hospital room and no plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense;
- If you are covered by two or more plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense;
- If you are covered by one plan that provides services or supplies on the basis of reasonable and customary fees and one plan that provides services and supplies on the basis of negotiated fees, the primary plan's fee arrangement shall be the Allowable Expense; and
- If your benefits are reduced under the primary plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible, and/or a penalty) because you did not comply with plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount that a duly licensed provider of health care services usually charges patients and that is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A plan that does not have a coordination of benefits rule consistent with this section shall always be the primary plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The plan that covers you as an enrollee or an employee shall be the primary plan and the plan that covers you as a dependent shall be the secondary plan.
- If you are a dependent child whose parents are not divorced or legally separated, the primary plan shall be the plan that covers the parent whose birthday falls first in the calendar year as an enrollee or employee.
- If you are the dependent of divorced or separated parents, benefits for the dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the plan of the parent with custody of the child;
  - then, the plan of the spouse of the parent with custody of the child;
  - then, the plan of the parent not having custody of the child, and
  - finally, the plan of the spouse of the parent not having custody of the child.
- The plan that covers you as an active employee (or as that employee's dependent) shall be the primary plan and the plan that covers you as a laid-off or retired employee (or as that employee's dependent) shall be the secondary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The plan that covers you under a right of continuation that is provided by federal or state law shall be the secondary plan and the plan that covers you as an active employee or retiree (or as that employee's dependent) shall be the primary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the plans that covers you is issued out of the state whose laws govern this policy, and determines the order of benefits based on the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this plan will be the secondary plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this plan is the secondary plan, this plan may reduce benefits so that the total benefits paid by all plans during a claim determination period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this plan would have paid if this plan had been the primary plan, and the benefit payments that this plan had actually paid as the secondary plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this plan;
- Whether a benefit reserve has been recorded for you; and
- Whether there are any unpaid Allowable Expenses during the claims determination period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the claim determination period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new claim determination period.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the primary plan, or if Cigna pays charges in excess of those for which Cigna is obligated to provide, Cigna will have the right to recover the actual payment made or the reasonable cash value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, health care plan or other organization. If Cigna makes a request, you must execute and deliver to Cigna such instruments and documents as it determines are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide Cigna with any information it requests in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the primary plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

Cigna will pay as the secondary plan as permitted by the Social Security Act of 1965 as amended for the following:

a. a former employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
b. a former employee's dependent, or a former dependent spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
c. an employee whose employer and each other employer participating in the employer's plan have fewer than 100 employees and that employee is eligible for Medicare due to disability;
d. the dependent of an employee whose employer and each other employer participating in the employer's plan have fewer than 100 employees and that dependent is eligible for Medicare due to disability;
e. an employee or a dependent of an employee of an employer who has fewer than 20 employees, if that person is eligible for Medicare due to age; and
f. an employee, retired employee, employee's dependent or retired employee's dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that part without premium payment, but has not applied, to be the amount he would receive if he had applied;
- Part B of Medicare for a person who is entitled to be enrolled in that part, but is not, to be the amount he would receive if he were enrolled; and
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any employee and his dependent or any former employee and his dependent unless he is listed under (a) through (f) above.

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your dependent (hereinafter individually and collectively referred to as a “participant,”) for which another party may be responsible as a result of having caused or contributed to an injury or sickness; and
- Expenses incurred by a participant to the extent any payment is received for him either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, Workers’ compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a participant incurs a Covered Expense for which, in the opinion of the plan or its Claims

Administrator, another party may be responsible or for which the participant may receive payment as described above:

- **Subrogation:** The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a participant from such party to the extent of any benefits paid under the plan. A participant or his/her representative shall execute such documents as may be required to secure the plan’s subrogation rights.
- **Right of Reimbursement:** The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in the paragraph above, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a participant:

- Grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the participant that is binding on any attorney or other party who represents the participant whether or not an agent of the participant or of any insurance company or other financially responsible party against whom a participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- Agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon; and
- Agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor dependent of said adult participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No participant shall make any settlement, that specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights here under, specifically: no court costs, attorneys' fees, or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," or "Attorney's Fund Doctrine."
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any participant, whether under comparative negligence or otherwise.
- In the event that a participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien, and/or constructive trust, as well as injunctive relief.

Rescission of Coverage

Your coverage may not be rescinded (retroactively terminated) by Baker Hughes unless you (or a person seeking coverage on your behalf) performs an act, practice, or omission that constitutes fraud, or you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact.

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/ Pharmacy Networks

The plan utilizes a network of providers. A separate listing of participating providers who participate in the network is available to you without charge by visiting **www.cignaenvoy.com** or by calling the toll-free telephone number on your ID card.

Your participating provider/pharmacy networks consist of a group of local medical practitioners and hospitals, of varied specialties as well as general practice or a group of local pharmacies who are employed by or contracted with Cigna.

Prescription Drug Program

Prescription Drug Program Benefits At-a-Glance

Type of Program	Prescription Drug program for members enrolled in a Baker Hughes Medical program
Employee Eligibility	U.S. Assignees/Rotators and eligible dependents enrolled in the Cigna International Medical Plan
When Coverage Begins	Coverage begins on your date of hire or your date of transfer.
Enrollment Period	Eligible employees are automatically enrolled in the Prescription Drug program upon enrolling in the Medical program.
Contact	• Cigna: **www.cignaenvoy.com** | **1-800-441-2668** (worldwide) or **302-797-3100** (collect outside U.S.) • **BakerHughesBenefits.com/Assignee/US** • The **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.)

Cigna Prescription Drug coverage (within and outside of the U.S.)

If you use the Cigna plan, you will pay 20% coinsurance up to the $2,000 Individual or $4,000 Family out-of-pocket maximum (combined with Medical).

You will pay the full price of the prescription drug at the time of purchase, and then submit a claim form for reimbursement.

Prescription Drug Costs

	Prescription Drug coverage	Cigna International Prescription Drug plan (within the U.S.)	Cigna International Prescription Drug plan (outside the U.S.)
	Deductible	**N/A**	**N/A**
30-day supply	Retail – generic	$7 copay	20% coinsurance after deductible (R&C applies)[1]
	Retail – formulary brand	25% ($30 minimum/$60 maximum)	
	Retail – non-formulary brand	30% ($60 minimum/$100 maximum)	
Specialty	Specialty retail or mail – generic	$7	20% coinsurance after deductible
	Specialty retail or mail – formulary brand	25% ($30 minimum/$60 maximum)	
	Specialty retail or mail – non-formulary brand	30% ($60 minimum/$100 maximum)	
90-day[2] supply	Retail or mail – generic	$21 copay	N/A
	Mail order or retail – formulary brand	25% ($30 minimum/$60 maximum)	
	Mail order or retail – non-formulary brand	30% ($30 minimum/$60 maximum)	
	Out-of-pocket maximum	In the U.S.: $2,000 Individual/$4,000 Family Outside the U.S.: $2,000 Individual/$4,000 Family Separate from Medical. Included in Medical out-of-pocket maximum.	In the U.S.: $2,000 Individual/$4,000 Family Outside the U.S.: $2,000 Individual/$4,000 Family Included in Medical out-of-pocket maximum.
	ID card	Same card as Medical	Same card as Medical

1 Usual and customary charges are the standard costs for services in a geographic area.

2 Home delivery is not available outside of the U.S.

Prescription Drug Benefits (purchased outside the U.S.)

If you or any one of your dependents, while insured for prescription drug benefits, incurs expenses for charges made by a pharmacy for medically necessary prescription drugs or related supplies ordered by a physician outside the U.S., Cigna will provide coverage for those expenses as shown in the Medical Schedule of Benefits. Coverage also includes medically necessary prescription drugs and related supplies dispensed for a prescription issued to you or your dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Coverage for prescription drugs and related supplies purchased at a pharmacy is subject to the coinsurance shown in the Schedule, after you have satisfied any applicable prescription drug deductible. Please refer to the *Schedule of Benefits* for any required coinsurance, deductibles, or maximums if applicable.

Exclusions and Limitations

No payment will be made for the following expenses:

- Drugs available over the counter that do not require a prescription by applicable law
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee
- Injectable infertility drugs and any injectable drugs that require physician supervision and are not typically considered self-administered drugs. The following are examples of physician-supervised drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables, and endocrine and metabolic agents.
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical AssociationDrug Evaluations or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.
- Prescription vitamins (other than prenatal vitamins), pediatric multivitamins containing fluoride, and dietary supplements
- Anabolic steroids
- Diet pills or appetite suppressants (anorectics)
- Prescription smoking cessation products
- Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration, and fade-cream products
- Replacement of prescription drugs and related supplies due to loss or theft
- Drugs used to enhance athletic performance
- Drugs that are to be taken by or administered to you while you are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution that operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals
- Prescriptions more than one year from the original date of issue

Dental Program

Dental Benefits At-a-Glance

Type of Program	Voluntary dental coverage		
Employee Eligibility	U.S. Assignees/Rotators who are: • Regular full-time employees or • Benefits-eligible part-time employees		
When Coverage Begins	Enroll and begin coverage on your date of hire or date of transfer.		
Enrollment Period	• New hires and employees transferring to a position with U.S. Assignee/Rotator benefits within 60 days of becoming eligible for coverage. If you do not enroll, you will not be able to elect coverage until the next Annual Enrollment period. There is no default coverage for employees who do not enroll. • Employees can make changes during Annual Enrollment or if they have a change in status (see the *Can I Make Changes After I Enroll?* information located in the *General Information* section). If you do not change the coverage in which you are enrolled during the Annual Enrollment period, you'll receive the same coverage you had the previous year, as long as you remain eligible.		
Dental Program	Cigna International Dental Plan		
Coverage Level	• You Only • You + Spouse • You + Children • You + Family		
Cigna International Dental Program	Maximum Annual Benefit	$2,000 (excluding orthodontia)	
	Deductible	$50 per person/$100 per family	
	Type of Service	**Program Pays**	**You Pay**
	Routine Preventive Services	100% (no deductible)	0%
	Basic Care Services	80% (after deductible)	20% (after deductible)
	Major Care Services	60% (after deductible)	40% (after deductible)
	Orthodontia (for dependent children up to age 19)	50% after deductible (subject to a $1,500 lifetime maximum)	50% after deductible (subject to a $1,500 lifetime maximum)
Contact	• Cigna: **www.cignaenvoy.com** | **1-866-441-2668** (worldwide) or **302-797-3100** (collect outside the U.S.) • **BakerHughesBenefits.com/Assignee/US** • The Benefits Center at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.)		

Note: Do not rely on this chart alone. It merely summarizes your benefits. For more detailed information, please contact Cigna or the **Baker Hughes Benefits Center.**

Important: **When you incur a dental expense**, you pay the full cost at the time of service. If you do not use a Cigna provider, you will need to file a claim through Cigna in order to be reimbursed. The claim form is the same one that is used for medical claims. If you have a question about a specific treatment, contact Cigna.

Payment of Benefits – Dental

To Whom Payable

Dental benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a non-participating provider even if benefits have been assigned. When benefits are paid to you or your dependent, you or your dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to recover that overpayment from the person to whom or on whose behalf it was made, or offset the amount of that overpayment from a future claim payment.

Dental Benefits Extension

An expense incurred in connection with a dental service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- For fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases;
- For a crown, inlay, or onlay, the tooth is prepared while he is insured and the crown, inlay, or onlay is installed within 3 calendar months after his insurance ceases; and
- For root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any dental service not shown above.

Vision Program

Vision Benefits At-a-Glance

Type of Program	Vision program for all eligible employees
Employee Eligibility	U.S. Assignees/Rotators who are: • Regular full-time employees • Benefits-eligible part-time employees
When Coverage Begins	Enroll and begin coverage on your date of hire or date of transfer. You are automatically enrolled in Vision coverage when you enroll in the Medical plan.
Enrollment Period	New hires and employees transferring to an eligible assignment within 60 days of becoming eligible for coverage.
Contact	• Cigna: **www.cignaenvoy.com** | **1-866-441-2668** (worldwide) or **302-797-3100** (collect outside the U.S.) • **BakerHughesBenefits.com/Assignee/US** • The Benefits Center at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.)

Under the Cigna International plan, you automatically receive vision coverage. This coverage is designed to help you and your family take care of your vision needs anywhere in the world.

When you receive vision care services, you pay the full cost at the time of service. You will then submit a claim form to Cigna for reimbursement. The claim form is the same one that is used for medical claims (please refer to the *How to File a Claim* section in the *Medical* section). Cigna will reimburse expenses for routine vision exams and medically necessary care, but not cosmetic work. **Each covered member receives 100% of covered hardware up to a $350 combined maximum per calendar year worldwide.**

Vision Schedule of Benefits

Each covered person is eligible for the following benefits each calendar year:

Benefit	International	U.S. In-Network/ U.S. Out-of-Network
Eye Exam Once every 12 consecutive months	100% (not subject to deductible)	100% (not subject to deductible)
Lenses and Frames Once every 12 consecutive months	100% Combined maximum $350 (lenses and frames)	100% (not subject to deductible) Maximum benefit: unlimited 100% (not subject to deductible) Combined maximum $350 (lenses and frames)
Exam Maximum Benefit	Unlimited	Unlimited
Hardware Maximum Benefit	$350	$350

Note: Do not rely on this chart alone. It merely summarizes your benefits. Please read the following pages for a more complete explanation of your coverage.

Expenses Not Covered

The following expenses are not covered:

- Orthoptic or vision training and any associated supplemental testing;
- Spectacle lens treatments, "add ons," or lens coatings not shown as covered in the Schedule of Benefits;
- Two pairs of glasses, in lieu of bifocals or trifocals;
- Prescription sunglasses;
- Medical or surgical treatment of the eyes;
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- Magnification or low vision aids;
- Any non-prescription eyeglasses, lenses, or contact lenses;
- Safety glasses or lenses required for employment;
- VDT (video display terminal)/computer eyeglass benefit;
- Charges in excess of the maximum reimbursable charge for the service or materials;
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy;
- Experimental or non-conventional treatment or device;

- High index lenses of any material type;
- Lens treatments or "add-ons," except rose tints (#1 & #2), and oversize lenses;
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society;
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or that is work-related; and
- Claims submitted and received in excess of one year (365 days) from the original date of service.

Other Limitations are shown in the *Exclusions and General Limitations* section.

Payment of Benefits – Vision

To Whom Payable

Vision benefits are payable to you, but are also assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses even if benefits have been assigned. When benefits are paid to you or your dependent, you or your dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to recover that overpayment from the person to whom or on whose behalf it was made, or offset the amount of that overpayment from a future claim payment.

Baker Hughes

Protection

The following section Benefits described under Protection are designed to protect your income if you are unable to work due to illness or injury. These benefits include:

Protection

- Salary Continuation

Protection

Salary Continuation

Baker Hughes helps you prepare for unexpected absences by providing you with Salary Continuation at no cost to you. The plan provides the continuation of your base pay during a disability for a period of up to 90 days or until recovery, whichever is earlier.

If you are disabled for longer than 90 days, you may be eligible for Long-Term Disability. Note: If you return to your home country while receiving Salary Continuation, your hardship and Goods and Services allowance is stopped.

Baker Hughes

Benefits Rights

Important Benefits Rights

Please read this section carefully. It contains information concerning the Baker Hughes Health programs described in this SPD, and it includes important facts and information about your rights as a program participant.

This SPD is designed to inform you about benefits that Baker Hughes provides and how you may receive them. However, your participation in any of the benefit programs is not a guarantee of continued employment. The Company reserves the right to retain employees at its own discretion, regardless of benefits offered to them. Nothing in this SPD should be interpreted as a limitation of or restriction on that right. Also, in general, you cannot sell, transfer, or assign, either voluntarily or involuntarily, the value of your benefit under any Baker Hughes Health program.

Keeping Your Health Information Private

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Under the federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Baker Hughes group health programs (the Health Programs) are required to protect the confidentiality of your private health information, and to provide individuals with notice of its legal duties and privacy practices with respect to that information.

The Health Programs, and Baker Hughes Company (as Program Sponsor), will not use or disclose health information protected by HIPAA, except when such use or disclosure is necessary for treatment, payment, Health Program operations (collectively known as TPO), or as permitted or required by other state and federal law. All of the Health Programs' business associates (organizations who have a contract with Baker Hughes Company to provide certain services, such as legal, actuarial, accounting, consulting, and data aggregation of financial circumstances) must also observe HIPAA's privacy rules. Furthermore, the Health Programs will not use or disclose Protected Health Information for employment-related actions and decisions (or in connection with any other Company employee benefit program), unless they have obtained your written authorization for such use and disclosure.

Protected Health Information (PHI) is "individually identifiable" health information, including genetic information, related to your physical or mental health or condition, services provided to you, or payments made for your care, which is created or received by a Health Program, a health care clearinghouse, or a health care provider and that is transmitted by electronic media or maintained in an electronic format, or transmitted or maintained in any other form or medium. Under HIPAA, you have rights with respect to your Protected Health Information, including:

How the Health Programs May Use Your Protected Health Information

In order to manage your health effectively, the Health Programs are permitted by law to use and disclose your Protected Health Information in certain ways, without your consent or authorization, as follows:

For treatment. So that you receive the right treatment and care, your Protected Health Information may be used as providers coordinate or manage your health care services. For example, your information may be used when your physician consults with a specialist regarding your condition.

For payment. To make sure that claims are paid correctly and you receive the benefits you are entitled to, your Protected Health Information may be used and disclosed to determine plan eligibility and responsibility for coverage and benefits. For example, your information may be used when a Health Program confers with another health program to resolve a coordination of benefits issue.

For health care operations. To ensure quality and efficient plan operations, your Protected Health Information may be used in a number of ways, including Health Program administration, quality assessment and improvement, and vendor review. Your information could be used, for example, when a Health Program contacts you to provide reminders or information about treatment alternatives or other health-related benefits and services available under the Health Program.

Your Protected Health Information may also be disclosed to certain designated employees of Baker Hughes Company (the program sponsor) in connection with these activities. Baker Hughes Company has designated a limited number of employees of its affiliates who are the only ones permitted to access and use your Protected Health Information for plan operations and administration. When appropriate, there are two types of Protected Health Information that may be shared with other Baker Hughes Company employees and its affiliates' employees:

- Enrollment/dis-enrollment data – information on whether you participate in the Health Program or whether you have enrolled or dis-enrolled from a Program option (e.g., HMO), and
- Summary health information – summaries of claims from which names and other identifying information have been removed for purposes of obtaining premium bids from health programs or modifying, amending, or terminating a Health Program.

Baker Hughes Company agrees not to use or disclose your Protected Health Information for any purposes not authorized by the HIPAA privacy regulations.

Permitted Uses and Disclosures

Federal regulations allow use and disclosure of your Protected Health Information by the Health Programs, without your authorization, for several additional purposes.

- Public health activities
- Disclosures to an appropriate government authority regarding victims of abuse, neglect, or domestic violence
- Oversight activities of a health oversight agency authorized by law
- Judicial and administrative proceedings
- Law enforcement activities
- To a coroner or medical examiner
- Research purposes, as long as certain privacy-related standards are satisfied
- To avert a serious threat to health or safety
- Specialized government functions (e.g., military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions, and other law enforcement custodial situations)
- Workers' Compensation or similar programs that provide benefits for work-related injuries or illness
- Other purposes required by law, provided that the use or disclosure is limited to the relevant requirements of such law

In Special Situations...

The Health Programs may disclose your Protected Health Information to a family member, relative, close family friend, or any other person whom you identify, when that information is directly relevant to the person's involvement with your care or payment related to your care. The Health Programs may also use your Protected Health Information to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, the Health Programs will use sound judgment to determine what is in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person's involvement with your health care.

The Health Programs are prohibited from using or disclosing your Protected Health Information when it is considered genetic information for underwriting purposes except to the extent that a Health Program is an issuer of long-term care policies.

Uses of Protected Health Information Requiring Authorization

For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions on the previous pages, the Health Programs are required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the group health plan has already undertaken an action in reliance upon your authorization.

- **Psychotherapy notes.** Save for certain limited exceptions, the Health Programs must obtain authorization for any use or disclosure of your psychotherapy notes.
- **Marketing.** The Health Programs must obtain authorization for all treatment and health care operations communications where it receives financial remuneration for making the communications from a third party whose product or service is being marketed.
- **Sale of Protected Health Information.** The Health Programs must obtain an authorization for any disclosure that is a sale of Protected Health Information. Such an authorization must state that the disclosure will result in remuneration to the Program.

Your Rights Regarding Protected Health Information

You have certain rights regarding your Protected Health Information. To exercise the rights described below, you must send a written request to the Benefits Department listed at the end of this notice.

Access: You have the right to inspect and receive a copy of your Protected Health Information, with limited exception. You have the right to request a readily-producible form in which your Protected Health Information may be delivered. If the Health Programs use or maintain an electronic health record of your Protected Health Information, you may obtain a copy in an electronic format, and, if you choose, direct the Health Programs to transmit a copy to a party you designate. The Health Programs may charge you a fee to copy and mail the information to you or to prepare a summary or explanation. In certain situations, the Health Programs may deny your request to see your Protected Health Information. You may be entitled to have a licensed health care professional review that denial.

Disclosure accounting: You have the right to request an accounting of certain disclosures made by the Health Programs during the six years prior to your request if applicable. However, you are not entitled to an accounting of disclosures made for payment, treatment, or health care operations, disclosures you authorized in writing, or other disclosures for which federal law does not require us to provide an accounting.

Restriction: You have the right to ask a Health Program to restrict how your Protected Health Information is used and disclosed for treatment, payment, and health care operations. You may also ask the Health Program to restrict disclosures to your family members, relatives, friends, or other persons you identify who are involved in your care or payment for your care. The Health Program is not, however, required to agree to such requests. You have the right to restrict certain disclosures of Protected Health Information to the Health Programs when you pay out of pocket in full for health care items or services.

Confidential communications: You have the right to request that you receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may only want to have information sent by mail or to a work address.

Amendment: You have the right to amend or correct inaccurate Protected Health Information. A request for amendment may be denied in certain circumstances (e.g., if the Protected Health Information is accurate and correct as it is). If the request is denied, you have the right to add a statement of your disagreement to your Protected Health Information.

Right to a paper copy of the notice: If you agree to receive notice of your rights under HIPAA electronically, you have the right to request and obtain a paper copy of those rights from the Health Program.

Right to Notice of Breach of Unsecured Protected Health Information. You have the right to receive notice in the event that unsecured Protected Health Information identifying you has been, or is reasonably believed to have been used, accessed, acquired, or disclosed in an unauthorized manner.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Health Program or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a HIPAA complaint with the program, please contact:

Baker Hughes Company
575 N. Dairy Ashford, Energy Center II
Houston, TX 77079-1117

The Health Programs will not retaliate against any individual for filing a complaint as described above.

The Health Programs maintain a privacy notice (i.e., Notice of Privacy Practices), which provides a complete description of your rights under HIPAA's privacy rules. The most recent version of the privacy notice is located on the Baker Hughes intranet. The Health Programs are required to abide by the terms of the notice currently in place, which went into effect on January 1, 2023. The Health Programs reserve the right to change the terms of its notice and to make the new notice provisions effective for all Protected Health Information that it maintains. The Health Programs will provide individuals with a revised notice on the Baker Hughes Intranet.

If you don't have Intranet access, contact your local human resources representative or the privacy officer to obtain the privacy notice. If you have questions about the privacy of your health information, please contact the Company's privacy officer.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Health Program or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a HIPAA complaint with the program, please contact:

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If you don't have Intranet access, contact your local human resources representative or the privacy officer to obtain the privacy notice. If you have questions about the privacy of your health information, please contact the Company's privacy officer.

The Health Program and Baker Hughes Company are treated as separate and independent entities that must exchange information to coordinate your program coverage. For the purpose of obtaining summary health information from vendors and to report summary health information to Baker Hughes Company, the program will share data such as claim reports with a listing of diagnosis and treatment (no individual employee information is included in this kind of report) with Baker Hughes Company. PHI will only be shared with Baker Hughes if Baker Hughes has certified that it will:

- Not further use or disclose PHI other than as permitted, as required by the plan documents, or as required by law;
- Ensure that anyone or any organization to which Baker Hughes Company provides PHI agrees to the same restrictions and conditions that apply to Baker Hughes Company;
- Not further use or disclose PHI for employment actions or decisions;
- Not further use or disclose PHI in connection with any Company benefits;
- Report to the Health Program any PHI use or disclosure that has not met HIPAA requirements;
- Make PHI available to an individual according to HIPAA's access requirements;
- Make PHI available for amendment, and incorporate amendments according to HIPAA's privacy rules;
- Make available any information required for an accounting of disclosures;
- Make available to the U.S. Department of Health and Human Services the Company's internal practices, books, and records relating to the use and disclosure of PHI from the group health plan to determine the plan's compliance with HIPAA;

- Return or destroy PHI received from the Health Program for the purposes for which the disclosure was made when no longer needed; and
- Ensure an adequate separation between the Health Program and the Company.

You May Obtain a Copy of the Notice of Privacy Practices

The Notice of Privacy Practices for the Health Programs explains how the programs use and disclose the Protected Health Information of individuals covered by the program. Baker Hughes has previously provided you with a copy of that notice. The Health Programs are required by HIPAA to periodically advise you of the availability of the Notice of Privacy Practices adopted by the Health Programs and how to obtain a copy. The most recent version of the Notice of Privacy Practices is located on the Baker Hughes Intranet. If you don't have Intranet access, contact your local human resources representative to obtain the privacy notice or the Baker Hughes privacy officer:

Baker Hughes Company
575 N. Dairy Ashford, Energy Center II
Houston, TX 77079-1117

Special Enrollment Rights

When certain events occur, as described in more detail below, you may have a special right to enroll yourself and/or your eligible dependents in the group health plans described in this SPD at a time other than an Annual Enrollment period. If you have any questions about special enrollment rights or would like to request special enrollment in one of the plans, you should contact the **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.).

Special Enrollment Due to Loss of Other Medical Coverage

If you or your eligible dependents have other group health plan coverage in place when you are initially eligible to enroll in the group health plans described in this SPD, you may decide not to enroll yourself or your eligible dependents in the Baker Hughes program at that time. If you or your eligible dependents later lose that other coverage, you or your eligible dependents may become eligible for a special enrollment right.

If your other coverage was group health plan continuation coverage mandated by COBRA, you will become eligible for special enrollment when your COBRA rights are exhausted. However, you will not become eligible if you lose COBRA coverage without exhausting your rights (for example, if you stop paying premiums). If your other group health plan coverage was non-COBRA coverage, you will become eligible for special enrollment if an employer that had been contributing to the cost of coverage stopped making those contributions or if your coverage terminated when you ceased to be eligible (for example, through legal separation, divorce or loss of dependent status). However, you must request special enrollment within 60 days after you or your qualifying dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Special Enrollment Due to Acquisition of a Dependent

If you are enrolled in one of the group health plans described in this SPD and during the year you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, your dependent will be eligible for special enrollment in the plan.

If you are not enrolled, but you are eligible for coverage under the group health plans described in this SPD, and during the year you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you and your eligible dependents will be eligible for special enrollment in the plans. In such instances, you can enroll without enrolling your dependents, or you and some or all of your qualifying dependents can enroll. However, your dependents may not enroll in the plan unless you also enroll (or are already enrolled) in the plan.

You must request special enrollment within 60 days after the applicable marriage, birth, adoption, or placement for adoption. Enrollments following a marriage, birth, adoption, or placement for adoption will be effective as of the date of the marriage, birth, adoption, or placement for adoption.

Special Enrollment for Certain Changes in Medicaid or CHIP Coverage

If you or your eligible dependent are eligible to enroll in one of the group health plans described in this SPD but are not enrolled, you or your eligible dependent will be entitled to enroll for coverage under the plan if:

- You or your eligible dependent were covered under a Medicaid program or under a state child health plan and that coverage was terminated because you or your eligible dependent lose eligibility for that coverage, or
- You or your eligible dependent become eligible under a Medicaid program or under a state child health plan for assistance with your premium payments due under one of the group health plans described in this SPD.

However, you must request enrollment in the plan not later than 60 days after the date of termination of the Medicaid plan or state child health plan coverage or the date you or your eligible dependent is determined to be eligible for the assistance.

Some states have a Medicaid program or a child health plan (CHIP) that can help pay for employer-provided group health plan coverage like that provided by the group health plans described in this SPD. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health plan premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact that program to find out if premium assistance is available to you.

If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state's Medicaid or CHIP program to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for coverage under the plan.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. The Medical program and the option offered under the Medical program are in compliance with this law.

Under the Act, the Medical program and the Claim Administrators that offer mastectomy coverage under the options offered under the plan must for any participant or beneficiary who elects breast reconstruction in connection with a mastectomy, cover:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The covered procedures will be performed in a manner determined in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provision consistent with those established for other benefits under the applicable option offered under the Medical program that describes the benefits under such program.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Claims Administrator should have paid. If this occurs, the program may pay the other plan the amount owed.

If the program pays you more than it owes, you should pay the excess back promptly. Otherwise, Baker Hughes may recover the amount in the form of benefits payable under any Baker Hughes funded benefit programs, including this program. Baker Hughes also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses.

If the plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to the *Refund of Overpayments* section.

Refund of Overpayments

If the plan pays for benefits for expenses incurred on account of a covered person, that covered person, or any other person or organization that was paid, must make a refund to the plan if:

- The plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by the covered person, but all or some of the expenses were not paid by the covered person or did not legally have to be paid by the covered person;
- All or some of the payment the plan made exceeded the benefits under the plan; or
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the plan paid in excess of the amount that should have been paid under the plan. If the refund is due from another person or organization, the covered person agrees to help the plan get the refund when requested.

If the covered person, or any other person or organization that was paid, does not promptly refund the full amount owed, the plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future benefits for the covered person that are payable under the plan; (ii) future benefits that are payable to other covered persons under the plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the Claims Administrator makes payments, with the understanding that the Claims Administrator will then reimburse the plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the plan. The plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in certain of the Baker Hughes Health programs, you're entitled to certain rights and protections under ERISA. ERISA provides that all program participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the program, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed for the program with the U.S. Department of Labor and available at the public disclosure room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the program, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the program's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time periods.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or at **www.dol.gov/ebsa**, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

COBRA

Tip!

You and your dependents should take the time to read this section carefully to understand your COBRA rights. If you have any questions after reading this section, call the **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.).

What is COBRA Coverage?

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), Baker Hughes must offer you and your qualifying family members the opportunity to temporarily extend coverage under the Baker Hughes group health programs at group rates in certain instances where that coverage, including coverage under an HMO, would otherwise end (called COBRA coverage). Your rights and obligations under COBRA are briefly summarized below.

COBRA coverage can become available to you when you would otherwise lose your group health coverage under the group health plans. It can also become available to other members of your family who are covered under the group health plans when they would otherwise lose their group health coverage. COBRA coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event described below, referred to as a "COBRA qualifying event."

To qualify to elect COBRA coverage, an individual must be covered under a group health plan on the day prior to a COBRA qualifying event listed below. Otherwise, the individual has no rights to elect COBRA coverage. However, once your spouse or other dependent gains coverage under COBRA, your covered spouse or dependent may elect to add eligible dependents according to the same provisions that apply to active employees covered under the group health plans.

COBRA Qualifying Events

If you're an active employee covered by a group health plan, you may elect COBRA coverage if your coverage under the plan is lost because:

- Your hours of employment are reduced, or
- Your employment terminates (other than for gross misconduct).

If you're a covered spouse of a covered active or former employee, you may elect COBRA coverage for yourself if your coverage under the group health plan is lost for any of these reasons:

- Your spouse dies;
- Your spouse's hours of employment are reduced or employment terminates (other than for gross misconduct);
- You are divorced or legally separated from your spouse; or
- Your spouse becomes entitled to coverage under Medicare.

If you're a covered dependent child of a covered active or former employee, you may elect COBRA coverage for yourself if your coverage under the group health plan is lost for any of these reasons:

- The covered employee dies;
- The covered employee's hours of employment are reduced or employment terminates (other than for gross misconduct);
- Your parents divorce or legally separate;
- You cease to qualify as a dependent child of the covered employee under the group health plan; or
- The covered employee becomes entitled to coverage under Medicare.

Should an employer declare bankruptcy, retirees may elect COBRA coverage, but only if the retiree's coverage ends or is substantially reduced on or after the retirement date but within one year prior to the start of the bankruptcy proceedings.

Type of Coverage Available Under COBRA

Continuation of coverage under Medical, Dental, and Vision is available under COBRA, and it is the same coverage provided to covered active persons on the day before the COBRA qualifying event. If coverage under one of the group health plans is modified for covered active employees, the COBRA coverage will also be modified in the same manner. During the Annual Enrollment periods, as long as you are entitled to COBRA coverage, you have the same Annual Enrollment period rights that covered active employees have to add or eliminate coverage of family members or to switch to another applicable benefit option under the group health plans.

COBRA Eligibility

To receive continuation coverage under COBRA, you or a family member **must** notify the **Baker Hughes Benefits Center** when a covered employee and spouse divorce or legally separate, when a dependent child of the covered employee ceases to qualify as a dependent child under the group health plan, or when a covered employee or covered dependent becomes disabled. You, or your spouse or dependent, must contact the **Baker Hughes Benefits Center** at **1-866-244-3539** within 60 days after the event and provide the necessary information regarding the event. If you do not provide timely information to the **Baker Hughes Benefits Center**, the **Baker Hughes Benefits Center** cannot provide notice of COBRA continuation coverage rights resulting from that event and you and/or your spouse or dependents will not be entitled to receive COBRA continuation coverage. After the **Baker Hughes Benefits Center** is notified that a COBRA qualifying event has occurred, you and your qualifying dependents will be notified of your rights (via mail) to elect COBRA coverage and provided with application materials. You then have 60 days from the post-mark date of those materials to call the **Benefits Center** to make COBRA elections. Covered employees may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

You do not have to provide Evidence of Insurability to elect COBRA coverage. The law also requires that you be allowed to enroll in an individual conversion health plan, if otherwise generally available under the group health plans, if coverage ends because of the expiration of the 18-month or 36-month, as applicable, continuation period.

Once you or your dependents are receiving COBRA coverage, if you change your marital status or if you, your spouse, or your dependents change addresses, you should notify the **Baker Hughes Benefits Center** immediately.

If you do not elect COBRA coverage, your coverage under the group health plans will end at the time of the applicable COBRA qualifying event. If you elect COBRA coverage, Baker Hughes is required to offer coverage which, at the time the coverage is being provided, is the same as coverage provided to similarly situated active employees or family members.

Electing COBRA Coverage for New Dependents

While you are enrolled in COBRA coverage, you may add new dependents to your coverage as long as you notify the **Baker Hughes Benefits Center** within 31 days of the date you acquire the new family member. Any children born to you or placed for adoption by you during the COBRA period may be enrolled immediately for the duration of the COBRA period, including any extended coverage in the event of multiple qualifying events.

COBRA Period

COBRA allows you to continue your coverage under a group health plan for up to the periods described below.

If You Experience One of these Qualifying Events	COBRA Coverage May be Elected for	Up to a Maximum of
Your death	Your spouse and/or dependent children	36 months
Your divorce or legal separation	Your spouse and/or dependent children	
Your children are no longer eligible for benefits under the group health plan	Your child	
Your eligibility for Medicare benefits	Your spouse and/or dependent children	
Your termination of employment (unless terminated for gross misconduct) or a reduction of work hours	You, your spouse, and/or dependent children	• 18 months generally 29 months, if you, your spouse, or your child covered under the group heath plan qualify for Social Security disability benefits due to a disability that existed the day of the qualifying event or began within the first 60 days of COBRA coverage and lasts at least until the end of the 18-month period of COBRA coverage • 36 months for a spouse and children, if another qualifying event (other than bankruptcy of your employer) occurs during the initial 18-month or 29-month coverage period, as applicable, the second qualifying event would have caused the spouse or dependent child to lose coverage under the group health plan had the first qualifying event not occurred and notice of the second qualifying event is properly given by the spouse or dependent child to the group health Plan Administrator • 36 months for the spouse and children, if you were entitled to receive Medicare within 18 months before your termination of employment or reduction of work hours

To be "disabled" for COBRA purposes, you or your spouse or dependent child must qualify for Social Security disability benefits and must have been disabled at the time of the qualifying event or become disabled within the first 60 days of COBRA coverage. To receive the up to 11-month extension of the COBRA continuation coverage period as a result of a qualifying disability, you or your spouse or dependent child must notify the **Baker Hughes Benefits Center** at **1-866-244-3539** of the disability before the end of the initial 18-month COBRA period. If you recover (are no longer disabled) you must notify the **Baker Hughes Benefits Center** 30 days after the date you are determined to no longer be disabled. If you recover within the initial 18-month COBRA period, and within 60 days after the date the Social Security Administration determination is made, you may keep your COBRA coverage for the remainder of the 18-month period. Should you recover in the 19th through the 28th month, your COBRA coverage will cease at the end of the month in which you're determined to no longer be disabled.

If a person becomes eligible for COBRA coverage as a result of more than one COBRA qualifying event, the maximum COBRA coverage period for the individual will never be more than 36 months total for all events (other than in certain bankruptcy situations). Notwithstanding any of the provisions of this SPD or any other document provided to you, COBRA coverage is provided under the group health plans only to the extent required by COBRA except as permitted by the Plan Administrator.

Ending COBRA Coverage

Your COBRA coverage will end immediately for any of the following reasons:

- Baker Hughes no longer provides group health coverage to any of its employees;
- You do not pay the premium for your coverage in a timely manner;
- You become entitled to Medicare after making your COBRA coverage election;
- You become covered under another group health plan, unless there is a pre-existing condition exclusion as explained below; or
- The maximum required COBRA coverage period expires.

If you become covered under another group health plan that excludes coverage for pre-existing medical conditions, you may keep your COBRA coverage until the earlier of:

- The date the pre-existing medical condition exclusion expires, or
- The date your COBRA coverage eligibility period ends.

Cost of COBRA Coverage

- You must pay the full required premium for your COBRA coverage, even if the COBRA coverage is primarily only for coverage of conditions that are excluded under another group health plan's pre-existing conditions exclusion. You will pay your COBRA coverage premiums on an after-tax basis.
- You or your eligible dependents will be charged 100% of the total cost for COBRA coverage plus a 2% administration fee. You'll receive information about the cost of COBRA coverage from the **Baker Hughes Benefits Center**. Coverage will end automatically at the end of the continuation period or if you or your dependents stop making COBRA premium payments.
- However, if you elect COBRA coverage due to termination of employment or reduction in work hours and then you qualify for Social Security disability benefits, your COBRA premium will be increased to 150% of the premium amount after 18 months of COBRA coverage. Please note that COBRA premiums are subject to change. However, COBRA participants will be notified of any rate change.
- If you elect COBRA coverage and pay the appropriate monthly cost, your existing coverage will continue from the date coverage is originally scheduled to end. The first payment, which must cover all back payments due, is due **45 days from the date your election is received**. As long as an individual remains eligible for COBRA, payments are due at the time set forth in the information provided by the **Baker Hughes Benefits Center**. If a payment is received after the due date and any applicable grace period, COBRA coverage ends and **cannot be reinstated**.

If You Return to Work with Baker Hughes Before COBRA Coverage Ends

If you return to work as an employee while you're on COBRA coverage, you may elect to participate in the group health plan as an active employee. Upon your return to active coverage, you and all of your covered dependents will not be subject to any pre-existing medical condition limitations for medical conditions.

Coverage Options besides COBRA Coverage

Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family through the health insurance marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at **www.healthcare.gov**.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) generally prohibits group health plans from using the genetic information of plan participants to discriminate in providing coverage or benefits. The Baker Hughes group health programs are administered by Baker Hughes to comply with the applicable requirements of GINA.

Qualified Medical Child Support Order (QMCSO)

If a Qualified Medical Child Support Order (QMCSO) is issued with respect to your child, that child will be eligible for coverage as required by the order.

A QMCSO is a judgment, decree, or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage for a child and relates to benefits under a group health plan, and satisfies all of the following:

1. The order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible under the plan;
2. The order specifies your name and last known mailing address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. The order provides a reasonable description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. The order states the period to which it applies; and
5. The order does not require the plan to provide coverage for any type or form of benefit or option not otherwise provided under the plan, with limited exceptions.

If the order is a properly completed national medical support notice, such notice meets the requirements above.

Any payment of benefits under the plan shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

When the Plan Administrator receives a medical child support order, the following steps will be taken. The Plan Administrator will:

- Notify both the eligible employee and the representative of each child covered by the order of receipt of the order;
- Furnish an explanation of the plan's procedures for determining whether the court order is a QMCSO;
- Determine if the order is qualified; and
- Notify the eligible employee and the representative of each child covered by the order of the determination and, if the order is determined to be qualified, provide the representative of the child covered by the order with a full explanation of the benefits hereunder.

Participants and beneficiaries under the plan can obtain, without charge, a copy of the plan's QMCSO procedures from the **Baker Hughes Benefits Center** by calling the **Baker Hughes Benefits Center** at **1-847-883-0945** (worldwide) or **1-866-244-3539** (toll-free in the U.S.) between 7 a.m. and 7 p.m. Central Time, Monday through Friday. The Plan Administrator is responsible for deciding whether the court order satisfies the conditions of a QMCSO.

Baker Hughes

Important Plan Information

Plan Administration and Funding

The Baker Hughes Health programs described in this SPD are administered and funded in different ways. Some of the programs are funded through insurance with participant and/or Company contributions as described in the separate sections. Others are funded wholly by participant and/or Company contributions.

Plan Administrator

Baker Hughes Company, the Plan Administrator, has discretionary authority to interpret plan provisions, construe unclear terms, determine eligibility for benefits, and otherwise make all decisions and determinations regarding administration of the Baker Hughes Health programs described in this SPD. By participating in the program, you (and your dependents or beneficiaries, if any) agree to accept the Plan Administrator's authority. You can contact the Plan Administrator as follows:

Baker Hughes Company
Attn: Employee Benefits
575 N. Dairy Ashford, Energy Center II
Houston, TX 77079-1117

Claims Administrator

For some of the Baker Hughes Health programs described in this SPD, Baker Hughes has delegated authority to third party administrators to administer benefit claims under the plan. The Claims Administrator for each benefit plan is listed on the following pages. Subject to Baker Hughes' overall authority as Plan Administrator, the Claims Administrator has discretionary authority to interpret plan provisions and is the named fiduciary to determine benefit claims.

Contributions to the Plans

The Baker Hughes Health programs described in this SPD are individually identified by name and number as shown in the following table. Each of these programs is offered under the Baker Hughes Welfare benefits. The records of each benefit program are kept on a calendar-year basis.

Claims Administrators

Employer or Plan Administrator/ Sponsor	Baker Hughes Company, LLC Attn: Employee Benefits Department 575 N. Dairy Ashford, Energy Center II Houston, TX 77079-1117
Program Sponsor's Employer Identification Number (EIN)	76-0207995
Program Name	Baker Hughes Company Health benefits program
Program Number	501
Plan Year	The plan year begins January 1 and ends December 31.
Agent For Service of Legal Process	Baker Hughes Company General Counsel 2001 Rankin Road Houston, Texas 77073
Program	**Medical Program**
Program Name	Baker Hughes Company Comprehensive Major Medical program
Program Type	Welfare program providing comprehensive medical benefits
Type of Administration	Fully insured
Program Number	05679C
Benefit Administrator	Cigna Global Health P.O. Box 15800 Wilmington, DE 19850
Program	**Prescription Drug Program**
Program Name	Baker Hughes Company Prescription Drug program
Program Type	Welfare program providing prescription medication benefits
Type of Administration	Fully insured
Program Number	05679C
Benefit Administrator	Cigna Global Health P.O. Box 15800 Wilmington, DE 19850

Program	Dental Program
Program Name	Baker Hughes Company Group Dental Care program
Program Type	Welfare program providing comprehensive dental benefits
Type of Administration	Fully insured
Program Number	05679C
Benefit Administrator	Cigna Global Health P.O. Box 15800 Wilmington, DE 19850

Program	Vision Care Program
Program Name	Baker Hughes Company Vision program
Program Type	Welfare program providing comprehensive vision benefits
Type of Administration	Fully insured
Program Number	05679C
Benefit Administrator	Cigna Global Health P.O. Box 15800 Wilmington, DE 19850

Rights of the Plan Administrator

The Plan Administrator (or its designee as it relates to functions delegated by the Plan Administrator) has complete and final discretionary authority to interpret the plan and maintain control over the operation and administration of the plan.

Benefit Claims Disputes

The following provisions apply to any benefits under the plan that are not insured by a third party or provided by an HMO or DMO. By accepting benefits under the plan, you agree to the following provisions.

Exhaustion of Administrative Remedies

You may not file suit in court or seek arbitration concerning a claim for benefits until you have exhausted your claims and appeals procedures under the plan.

Venue for Litigation

Venue for litigation will be in Houston, Texas.

Controlling Law

Subject to the provisions of ERISA that may be applicable and provide to the contrary, the plan will be construed, regulated and administered under the laws of the state of Texas. All provisions of the plan will be construed, regulated and administered in accordance with the laws of Texas, and, to the extent applicable, by the laws of the United States.

Limitations on Legal Actions

You may not bring any action (whether litigation or arbitration) pertaining to a claim for benefits under the plan following the earlier of (1) 365 days after the final denial of your claim for benefits, or (2) the applicable limitations period under ERISA (which is the limitations period under Texas contract law).

Assignments of Benefits

No benefits under the plan may be assigned by you (except for assignments expressly authorized by the administrator) or may be subject to attachment by, interference with, or control of any of your creditors, or may be taken or reached by any legal or equitable process in satisfaction of any of your debts or liabilities prior to your actual receipt of benefits under the plan. Any attempted conveyance, transfer, assignment, mortgage, pledge, or encumbrance of plan benefits prior to payment to you will be void, whether that conveyance, transfer, assignment, mortgage, pledge, or encumbrance is intended to take place or become effective before or after any payment. The sponsor, the employers, the Administrative Committee, insurer, HMO or DMO will never under any circumstances be required to recognize any conveyance, transfer, assignment, mortgage, pledge, or encumbrance by you of plan benefits, or to pay any money or thing of value to any of your creditors or assignees. (These prohibitions against the alienation of your plan benefits will not apply to assignments under Qualified Medical Support Orders.)

Payments to Minors and Incompetents

If any person entitled to receive any benefits under the plan is a minor or is determined by the Administrative Committee, in its sole discretion, to be incompetent, the Administrative Committee in its discretion may pay such benefits to the duly appointed guardian or conservator of such person or to any third party who is authorized (as determined in the discretion of the Administrative Committee) to receive any benefit under the plan for the account of such participant or dependent. Such payment will operate as a full discharge of all liabilities and obligations of the Administrative Committee and all other persons under the plan with respect to such benefits.

No Vested Right to Benefits

No person will have any right to, or interest in, any benefits provided under the plan, except as specifically provided under the plan.

Name and Address Changes

You are responsible for notifying the Administrative Committee of any change in your name or address. If any check in payment of a benefit hereunder (which was mailed to your last address of the payee as shown on the Administrative Committee's records) is returned unclaimed, further payments under the plan will be discontinued until the Administrative Committee directs otherwise.

Change in Marital Status

You must inform the plan as to any change in your marital status and until so informed the plan will be entitled to rely on your assertion of marital status as originally established.

Modifications of the Plan

The following provisions apply to any benefits under the plan that are not insured by a third party or provided by an HMO or DMO. By accepting benefits under the plan, you agree to the following provisions.

No Oral Modifications

No person has the authority to orally modify the plan or this Summary Plan Description. So, neither you nor any person claiming through you may rely upon any oral representations of any person concerning the coverage or benefits provided under the plan, and no separate contract will be created with any person as a result of the oral statement.

Written Modifications

The plan is comprised of only the official plan document and this Summary Plan Description (to the extent not inconsistent with the official plan document, as amended in writing by the sponsor from time to time). You are not entitled to rely on any written document other than the official plan document and this Summary Plan Description (to the extent not inconsistent with the official plan document) with regard to the coverage or benefits provided under the plan. No separate contract will be created with the sponsor as a result of any other written document relating to welfare benefits (within the meaning of ERISA) unless the other written document is approved and signed by the director, Total Rewards, of the sponsor.

Plan's Right of Reimbursement

The following provisions apply to any benefits under the plan that are not insured by a third party or provided by an HMO or DMO. By accepting benefits under the plan, you agree to the following provisions.

- **General.** If you (or your guardian or estate) receive any plan benefits as a result of an injury or illness for which you (or your guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under the plan for such benefits will only be made on the condition and with the understanding that the plan will be reimbursed. Such reimbursement will be made by you (or your guardian or estate, legal counsel or other party who holds the recovery proceeds) to the extent of, but not exceeding, the total amount payable from (1) any policy or contract issued by any insurance company or carrier, or (2) any third party, plan, or fund as a result of judgment or settlement.

  By electing coverage and accepting benefits under the plan, you, on behalf of yourself (or your guardian or estate or legal counsel or person claiming through him or her [collectively, "interested persons"]) are deemed to acknowledge and agree that the plan will be reimbursed in full before any amounts (including but not limited to attorneys' fees incurred by you or interested persons) are deducted from the recovery proceeds (the proceeds) for any reason, without regard to the sufficiency of the recovery. The amount of the plan's reimbursement will not be reduced by virtue of any characterization of the proceeds in any settlement agreement or other agreement. For example, the plan's right of recovery will not be negatively affected by virtue of the fact that a settlement agreement allocates a portion of the proceeds to attorneys' fees, future medical costs, pain and suffering, a special needs trust, or otherwise.

  The plan will have a first priority lien on any and all proceeds recovered until the plan has been reimbursed in full for any benefits paid under the plan with respect to the injury or illness, whether or not the participant or dependent is fully compensated for his or her loss. No doctrine, including but not limited to the "make whole" doctrine or the "common fund" doctrine, will apply to qualify the plan's right of reimbursement. You will be responsible for all attorneys' fees incurred by you in seeking a recovery against a third party or parties; the plan will have no liability with respect to such attorneys' fees.

- **Duty of cooperation.** You on behalf of yourself and each interested person are deemed to agree to cooperate fully with the plan and the employer in asserting and protecting the plan's right of reimbursement. You on behalf of yourself and each interested person are deemed to agree to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect the plan's reimbursement right. You on behalf of yourself and each interested person are deemed to agree to refrain from taking any action that would frustrate or impede the plan's right of reimbursement.

- **Duty to notify the Administrative Committee of potential third party liability by third party.** You are deemed to agree on behalf of yourself and each interested person to notify the Administrative Committee as soon as administratively practicable, in writing, of the existence of any potential third party liability with respect to any injury or illness for which the plan may pay benefits.

- **Obligation to keep Administrative Committee apprised of developments.** You are deemed to agree on behalf of yourself and each interested person to promptly notify the Administrative Committee of any developments of which you are aware that may impact the plan's reimbursement rights.

- **No settlement or compromise without the assent of the employer**. You are deemed to agree on behalf of yourself (or your guardian or estate or legal counsel) to not enter into any settlement or compromise agreement concerning proceeds without the prior express approval of the employer.

- **No disposition of proceeds until plan has been reimbursed in full.** You are deemed to agree on behalf of yourself (or your guardian, estate, legal counsel, or other representative) to not dispose of any proceeds before the plan has been reimbursed in full.

- **Constructive trust.** You are deemed to agree on behalf of yourself and each interested person that any proceeds held by any such person will be deemed to be held in constructive trust for the benefit of the plan until the plan's reimbursement rights with respect there to have been satisfied in full. Any person who holds such proceeds in a constructive trust for the benefit of the plan will be subject to liability under ERISA if he or she disposes of such proceeds prior to the satisfaction of the plan's reimbursement rights. You are deemed to agree on behalf of yourself and each interested person that any person who holds proceeds in constructive trust for the plan is a fiduciary with respect to the plan within the meaning of ERISA and will comply with the fiduciary standards of ERISA with respect to such proceeds until the plan's reimbursement rights relating to such proceeds have been satisfied in full.
- **Forfeiture, withholding or offset of benefits.** If you or an interested person fails to comply with the provisions of this requirement of this *Plan's Right of Reimbursement* section, at the Administrative Committee's discretion, your benefits under the plan may be forfeited and the plan will have no obligation to pay benefits otherwise due with respect to you until the plan has recovered an amount equal to the amount of proceeds it would have been reimbursed had this section been complied with in full.
- **Coverage under the plan is conditioned upon agreements under this section.** The coverage of you under the plan is conditioned upon the understanding that you agree to and will comply with all of the terms of this section.

Plan's Right of Subrogation

The following provisions apply to any benefits under the plan that are not insured by a third party or provided by an HMO or DMO. By accepting benefits under the plan you agree to the following provisions.

- **General.** If you (or your guardian or estate) receive any plan benefits as a result of an injury or illness for which you (or your guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under the plan for such benefits will only be made on the condition and with the understanding that the plan will be subrogated to, and may enforce your rights against the third party or parties in connection with such illness or injury. The plan's rights specified in this *Plan's Right of Subrogation* section are in addition to, not in lieu of the plan's rights specified in *Plan's Right of Reimbursement*.
- **Duty of Cooperation.** You on behalf of yourself and each interested person are deemed to agree to cooperate fully with the plan and the employer in asserting and protecting the plan's right of subrogation. You, on behalf of yourself and each interested person, are deemed to agree to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect the plan's subrogation right. You, on behalf of yourself and each interested person, are deemed to agree to refrain from taking any action that would frustrate or impede the plan's right of subrogation.
- **Obligation to keep Administrative Committee apprised of developments.** You, on behalf of yourself and each interested person, are deemed to agree to promptly notify the Administrative Committee of any developments of which you are aware that may impact the plan's subrogation rights.
- **Forfeiture, withholding or offset of benefits.** If you or an interested person fail to comply with the requirements of this section, at the Administrative Committee's discretion, your benefits under the plan may be forfeited and the plan will have no obligation to pay benefits otherwise due with respect to you until the provisions of this section are complied with.
- **Coverage under the plan conditioned upon agreements under this section.** Your coverage under the plan is conditioned upon the understanding that you agree to and will comply with all of the terms of this section.

Benefit Administrators and Claims Payers

Baker Hughes Company has contracts with Benefit Administrators and claims payers. These providers are independent contractors and Baker Hughes is not responsible for any acts or omissions of any of these organizations, their providers, or independent contractors, including the quality of goods and services provided through any health care provider or program.

Plan Amendment or Termination

Although Baker Hughes Company intends to continue the Baker Hughes Health programs described in this SPD, Baker Hughes Company reserves the right to terminate or amend all or any of those plans in whole or in part at any time and for any reason. Baker Hughes Company's right to amend or terminate those plans includes, but is not limited to, changes in the eligibility requirements, premiums, or other payments charged, benefits provided, and termination of all or a portion of the coverage provided under the plan. If a plan is so amended or terminated, you'll be subject to all the changes effective as a result of such amendment or termination, altered or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any plan benefit, other than payment of any covered expenses you incurred prior to the plan amendment or termination.

Baker Hughes Company reserves the right to modify, amend, or terminate a plan, in whole or in part, if changes in the law or other conditions make it necessary.

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